

After School Care Enrolment Form 2018

Please take the time to **complete all questions** on this form. If you have more than one child attending the program please complete a separate form for each child. If you have any questions about this form or the program please contact the Educational Leader.

Child Information

Family Name: _____ Given Names: _____

Address: _____

Suburb: _____ Postcode: _____

Date of Birth: ____/____/____ Gender: _____ **Centrelink CRN:** _____

Is the child of Aboriginal or Torres Strait Islander origin (*circle*)? Yes No

Has the child been fully immunised (*circle*)? Yes No

Will you be using NDIS funding to pay your fees (*circle*)? Yes No

If yes, our NDIS Coordinator will contact you to create a Service Agreement before you can start.

Parent/Guardian Information

Parent/Guardian 1 (Claiming Centrelink Entitlements)

Family Name: _____ Given Names: _____

Relationship to Child: _____

Address: as per child or _____

Suburb: _____ Postcode: _____

Phone Numbers: Home: _____ Mobile: _____

Work: _____

Claiming Parent's Date of Birth: ____/____/____ **Claiming Parent's CRN:** _____

Email Address (for invoice): _____

Please note that you must include your date of birth and CRN to receive your Centrelink entitlements. **You must contact the Family Assistance Office on 13 61 50 to register.**

Parent/Guardian 2

Family Name: _____ Given Names: _____

Relationship to Child: _____

Address: as per child or _____

Suburb: _____ Postcode: _____

Phone Numbers: Home: _____ Mobile: _____

Work: _____

Custody DetailsWho does the child reside with (*circle*)?

Both Parents

Mother

Father

Other _____

Please provide details of any court orders, parenting orders or parenting plans relating to the powers, duties, responsibilities or authorities of any person in relation to the child, access to the child, the child's residence or the child's contact with a parent or other person:

If court orders, parenting orders or parenting plans exist relating to the child please attach a copy to this enrolment form to be kept confidentially

Authorisations

An authorised nominee is a person who has been given permission by a parent/guardian to collect the child from the program. Those listed below will also be contacted in the situation where the parent/guardian cannot be contacted. They can consent to medical treatment and the administration of medication to your child.

Please note: Anyone collecting your child must bring appropriate identification and must be over 18 years of age. You will need to provide written consent for anyone not on this list to pick up your child.

Nominee 1

Family Name: _____ Given Names: _____

Relationship: _____ Home phone: _____

Work phone: _____ Mobile phone: _____

Address: _____

Nominee 2

Family Name: _____ Given Names: _____

Relationship: _____ Home phone: _____

Work phone: _____ Mobile phone: _____

Address: _____

Nominee 3

Family Name: _____ Given Names: _____

Relationship: _____ Home phone: _____

Work phone: _____ Mobile phone: _____

Address: _____

Nominee 4

Family Name: _____ Given Names: _____

Relationship: _____ Home phone: _____

Work phone: _____ Mobile phone: _____

Address: _____

Medical Information

Doctor/Medical Centre: _____

Phone Number: _____

Medicare Number: _____

Ambulance Cover (*circle*) – Yes No

Immunisation Status

Has the child been fully immunised (*circle*)? Yes No

If **yes**, please attach a copy of your child's immunisation certificate.

If **no**, please provide an exemption letter from your GP.

In some cases when there is an outbreak of a vaccine preventable disease, unimmunised children or children who have not had their immunisation certificate provided to the service will be excluded from the program as per the period of exclusion of contacts recommended by the National Health and Medical Research Council. A copy of the exclusion periods table can be found in the Parent Handbook.

Anaphylaxis/Asthma/Diabetes

Has your child been diagnosed at risk of anaphylaxis, asthma or diabetes (*circle*)? Yes No

If yes, please record here:

In the case of asthma, anaphylaxis or diabetes, you are required to provide a copy of the relevant management plan. Please see the parent handbook for more information.

Has the relevant medical management plan been provided to the service (*circle*)? Yes No

Other Medical Conditions

Does your child suffer from any other medical conditions that staff need to be aware of (*circle*)?

Yes No

If yes, please record here:

In the case of a serious medical condition, you are required to provide the program with the **completed medical management plan and a risk minimisation plan** which can be found at the end of this enrolment form. Please see the parent handbook for more information.

Has the relevant medical management plan been provided to the service (*circle*)? Yes No

Additional Needs

Please complete the following with **as much detail as possible**. This helps up to best support your child and ensure that they are happy and safe whilst at the program. You are required to fully disclose information about your child's additional needs for the program.

Preferred Methods of Communication

- Verbal
- Written
- Key Word Sign
- Symbols (e.g. PODD book, Compic, Proloquo2Go)
- Gesture/facial
- Other _____

Sensory Needs

Social/Emotional Needs

Physical Needs

Mealttime Assistance: _____

Toileting Assistance: _____

Manual Handling/Lifting: _____

Behaviour (including self-injurious behaviour)

Please identify specific behaviours displayed, triggers for these behaviours and strategies you use at home to reduce or stop the behaviours.

Behaviour	Trigger	Strategy
<i>E.g. Jane screams and scratches her skin E.g. John will open doors and gates to abscond</i>	<i>E.g. Being told to stop doing an activity without warning E.g. Remaining inside for longer than 30 minutes</i>	<i>E.g. Provide countdown timer 5 minutes in advance E.g. Provide outside access for play every 30 minutes</i>

Cultural Information

Language spoken at home: _____

Interpreter required (*circle*)? Yes No

Relevant cultural details, food restrictions, activities, etc.:

General Information about Your Child

Observed Interests: _____

Dislikes/Fears: _____

Program Usage

Starting Date: _____

Campus (*circle*): Sunbury (skip page 12) Melton (complete page 12)

Attendance type (*circle*): Casual Weekly (complete table below)

	Monday <input type="checkbox"/>	Tuesday <input type="checkbox"/>	Wednesday <input type="checkbox"/>	Thursday <input type="checkbox"/>	Friday <input type="checkbox"/>
Expected Time of Pick Up					

Parental Permission

Please indicate below if you give permission for your child to participate in the following:

PG rated movies (*circle*): Yes No

Having 30+ SPF sunscreen applied (*circle*): Yes No

Being photographed for documentation purposes (*circle*): Yes No

At times we take photos and videos that may be used on our website. This allows other families to see what services we offer and the benefits for children and families. Do you give permission for photo or video content of your child to be used on our website in regards to the After School Care program (*circle*)? Yes No

Terms and Conditions

- I, the undersigned, (a person with lawful authority of the child referred to in this enrolment) declare that the above information is true and correct and undertake to immediately inform the program in the event of any change to this information.
- I understand that completion of this enrolment form will not mean definite inclusion in the program. I acknowledge that enrolments will be granted in the order of receipt and will not exceed the maximum places allowed under licensing agreements.
- I agree to abide by all policies and procedures of the program.
- I agree to pay my fees regularly and on time. I understand that failure to pay my account for two weeks after the due date may result in my child being excluded until the payment has been received. I understand that Distinctive Options After Hours Care cannot guarantee that a place will be available after the exclusion period.
- I will ensure that my child is collected on time every night. I understand that there will be late fees incurred if I fail to do so. I understand that constant failure to collect my child will result in exclusion from the program.
- I agree to sign attendance sheets for all sessions my child attends. I agree to inform staff of any absences before 11am or else I will be charged. I understand that if I am using NDIS funding to pay fees, I must give at least 24 hours notice or else I will be charged.
- I agree to inform program staff of casual attendances at the earliest possible time, before 11am at the latest. I agree that if I do not inform program staff and my child turns up, I or an authorised person will collect the child immediately. I understand I may be charged if this occurs.
- I understand that if my child is behaving in a manner that is dangerous to themselves, other children or staff, they may be excluded from the program.
- In the event that my child is injured or becomes ill during the program, either I or an authorised person will collect the child as soon as practical.
- In the event of any unforeseen accident or illness, I authorise the coordinator or person in charge to obtain such medical assistance that may be required and agree to meet any expenses incurred for such treatment. I authorise medical treatment from a registered medical practitioner, hospital or ambulance service, and transportation by ambulance should this be required.
- I acknowledge that my child will not attend the program if suffering from an infectious or contagious disease.
- If there is an incidence of an infectious or contagious disease and my child is not fully vaccinated, I understand that they will be required to stay away from the program.
- I acknowledge that Distinctive Options does not accept any liability for personal injury, property damage or loss sustained by any participant as a result of his or her participation in the program due to any cause unless negligence of Distinctive Options or its employees is proven.

I _____ (please print full name) declare that the information provided in this enrolment form is complete, true and correct. I approve of the enrolment terms and conditions and agree to abide by the requirements of the after school care policy and procedures document.

Signature: _____

Date: _____

Consent to Share Information with Your Child's School

Information for Parents and Guardians

To provide the best possible care for your child, Distinctive Options needs to communicate with your child's school to ensure we have a complete picture of your child's needs. Information about your child may be accessed through viewing their school records and speaking with staff at your child's school.

Confidentiality

All information about your child that is collected from your child's school is stored securely in a locked filing cabinet at the program and is only accessible by After School Care staff at Distinctive Options. Any information collected is subject to the Privacy Act 1988 and will remain confidential and secure except where:

1. Failure to disclose the information would place you or another person at serious and imminent risk; or
2. There is an obligation to disclose the information under the Commission for Children and Young People Act (2000); or
3. It is subpoenaed by a court; or
4. Your prior approval has been obtained; or
5. If disclosure is otherwise required or authorised by law.

Parent/Guardian Consent

By signing below I acknowledge that I have read the above statement and agree to the sharing of information about my child between Distinctive Options and my child's school (selected below).

Child's Full Name: _____

Child's School: *(please tick)*

Melton Specialist School

Sunbury and Macedon Ranges Specialist School

Parent/Guardian's Full Name: _____

Signature: _____

Date: ____/____/____

PERMISSION FOR RELEASE OF INFORMATION TO DISTINCTIVE OPTIONS AFTER SCHOOL CARE PROGRAM

To: The Principal

I _____ (Parent/Guardian Name)

Of _____ (Address)

Telephone: _____

give permission for Melton Specialist School to release Verbal information and/ or reports and documents and relevant information from the DET Confidential Student File/s and any other appropriate Behaviour Support Documents held about my child/ren if requested:

_____ D of B ____/____/____
(Student's Name)

_____ D of B ____/____/____
(Student's Name)

I understand that any information provided will be managed with appropriate confidentiality and sensitivity.

Signed: _____

Parent/Guardian Name: _____

Date: _____

OR

Verbal permission was given by _____ Parent/Guardian

On the _____ (date) to release information about the above named child to the identified person at the school.

Signed: _____ **Principal**

Date: _____

Child Medical Management Plan

Child's name: _____

Date of birth: ____/____/____

Medical condition: _____

Severity: _____

What medication is your child currently taking:

Will staff require specific training for the medical condition? If so, please provide details here:

Details about the medical condition:

What symptoms should staff be aware of:

Action Plan

If staff identify the above symptoms, they should:

If your child does not respond to initial treatment, staff should:

An ambulance should be called when:

Risk Management Plan

Risk What could lead to a medical emergency?	Strategy What can be done to reduce this risk?	Responsible
<i>E.g. Consumption of peanuts and eggs</i>	<i>E.g. Inform families and ensure peanuts and eggs are not brought in to the program</i>	<i>Room leader</i>

Communication Plan

Strategy	Responsible	Date
Provide a copy of the medical conditions policy to the child's family	Educational Leader	
Photocopy the plan and place a copy in the child's folder in the filing cabinet and a copy in the emergency book	Educational Leader	
Ensure staff are aware of the medical condition and the locations of the plan	Educational Leader	
Where the condition is anaphylaxis, display a notice of this at the service entry	Educational Leader	
Agree to inform the leader of any new medical conditions or any changes to the current medical condition that your child has	Parent/guardian	

Educational Leader signature: _____

Parent/guardian's signature: _____

Date developed: ____/____/____

Date to be reviewed: ____/____/____

Medication Authority Form

Child Information

Surname: _____ First name: _____

Period of authorisation: From ____/____/____ To ____/____/____

Medication Information

Name of medication: _____ Expiry date: ____/____/____

Dose required: _____ Time/s required: _____

Method of administration (e.g. oral, eye, ear, inhaled, etc.) and special instructions:

Known family history of allergies involving medication:

Parent Authorisation

Parent/guardian name: _____

Parent/guardian signature: _____

Date: ____/____/____