OSHC Programme 2015
Child Enrolment Form
Child Information - 1 form per child

Confidential: Restricted Access
(This information is confidential and will be available only to supervising staff and emergency medical personnel.)

Family Name ___________________________ Child's Name ___________________________
Date of Birth ___________________________ Review Date ___________________________
Medic Alert Number (if relevant) __________ Review Date ___________________________

Health Support
Does your child have a health care need that could affect their safety at Out of School Hours Care?   No    Yes
If YES, please tick the boxes below that show your child's health care needs:

- Asthma
- Epilepsy
- Heart Disorder
- Vision Impairment
- Seizures/convulsions
- Allergies (eg bees, peanuts, dairy)
- Diabetes
- Incontinence
- Joint Disorder (eg arthritis)
- Ear Disorder (eg drainage tubes)
- Hearing Impairment
- Communication difficulties
- Skin condition (eg dermatitis)
- Swallowing/choking difficulties
- Other eg Penicillin (Please give details)

Health Care Plan
Out of School Hours Care staff need a written health care plan from your child's doctor/treating health professional to plan for any special health needs. Have you attached the health care information from your child's doctor/treating health professional?

- If NO, staff will provide standard supervision for safety and first aid
- If YES, write down what you have attached (eg Asthma? Epilepsy / Diabetes care plan).

Medication
Does your child have any chronic health conditions? (e.g. Asthma/Epilepsy/Diabetes)?

- No    Yes    If YES, please attach a medication plan from your health care professional detailing the medical condition, the correct dosage of medication if required and how the condition is managed.

(*) Doctors Name ___________________________ Clinic Name ___________________________
Address ___________________________________________ Phone Number ___________________________

This information will be used by supervising staff and is a requirement for the National Quality Assurance Regulations for OSHC. Are there any special dietary requirements relating to your child?

- No    Yes    If YES, please attach a modified food plan from your doctor or treating health care professional.

Does your child require medication for behavioural reasons?

- No    Yes    If YES, please attach a medication plan from your health care professional.

Does your child have any medication that needs to be administered/self-administered during their time at OSHC?    No    Yes
If yes, please note that all medication must be supplied in the original container with the original pharmacy label, including the child's name, the dose and how it has to be administered. Please attach a Permission to Administer Medication Form. This must be signed by the parent/doctor before medication can be administered by OSHC staff or self-administered by a child over 8 years of age.
Family Name  ________________________________  Child's Name  ________________________________
Date of Birth  ___________________________________________
Child's Customer Reference Number (CRN):  ___________________________________________

**Days Requiring Care - Regular Days**  Please tick

<table>
<thead>
<tr>
<th>Before School Care</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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<tbody>
<tr>
<td>After School Care</td>
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If your child only needs the service on a casual basis, please indicate the possible days and how often this will be required:

Please indicate if your child has any co-curricular activities after school

**Child Profile**

Friends in OSHC:  ___________________________________________
Food likes/dislikes:  ___________________________________________
What sporting activities and/or other activities or hobbies does your child enjoy? eg: lego, craft, soccer, etc:  ___________________________________________
What values and attitudes would you like your child to have/learn?:  ___________________________________________
Any other details about your child that we should be aware of: e.g. diet, culture, religion:  ___________________________________________

Has your child been excluded from another OSHC service?:  ___________________________________________
If not enrolled at Mercedes College, please specify the school your child is currently attending:  ___________________________________________

**Video / DVD Consent Form**

Due to the shortage of G rated movies at video stores, we have decided that we will start to borrow new release movies that are rated PG. These films will be picked by the OSHC Director and will be suitable for children’s viewing.

If you do not wish your child to watch PG movies, please indicate below and we will ensure that there is an alternative activity provided.

I give/do not give permission for:

(please print)  ________________________________  class:  ________________________________  to watch PG movies.

Parent/Guardian Signature:  ________________________________  Date:  ________________________________

I certify that the information entered on these forms is true to the best of my knowledge and I undertake to inform the OSHC service if any of these details change.

Parent/Guardian Signature:  ________________________________  Date:  ________________________________
Mercedes College is a co-educational, Reception to Year 12 Catholic school in the Mercy tradition, providing a caring and supportive learning environment.

540 Fullarton Road  Springfield  South Australia 5062
T +61 8 8372 3200  F +61 8 8379 9540
mercedes@mercedes.catholic.edu.au
www.mercedes.catholic.edu.au