

BONDI BEACH OSHC CENTRE

Phone: 0433167164 email: bboshc@primaryoshcare.com.au

Enrolment Form

Child's Given Name		Child's Family Name		Male/Female
Address				
Home Phone	Child's DOB	Legal Guardian	Primary Language	
OSHC Start Date	Date Started School	Child's CRN	Religion/Cultural Background	

	PARENT 1 (CCB Claimant) (fees billed to this person)	PARENT 2
Relationship to child		
Given Name		
Family Name		
Home Address		
DOB		
CRN		
Phone (H)		
Phone (M)		
Phone (W)		
Email		

MEDICAL INFORMATION	Has your child had any of the following:-		
Doctors Name	German Measles	Chicken Pox	Other
Address	Mumps	Hepatitis	
	Measles		
Phone No	Is there any other information you wish us to know about your child? (Special food requirements/religious considerations/ fears etc)		
Contact Doctor Yes / No			
Medicare No			
Private Health Fund Particulars			
Is your child on any regular medication or have any disabilities, food sensitivities or allergies we should know about? No / Yes (give details)			

Siblings attending another Childcare Centre?	Yes/No	How Many?
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Alternative Contact Information	Contact 1	Contact 2	Contact 3
Person's Name			
Relationship to child			
Home Address			
Phone (H)			
Phone (W)			
Phone (M)			
Emergency. Release	Yes / No	Yes / No	Yes / No
Authority to pick up	Yes / No	Yes / No	Yes / No
Is there anyone prohibited from having contact with or collecting the child? (Court Order required if Parent is prohibited)			

List at least 2 people who are authorised to collect your child and at least 2 people that we may contact if we cannot contact you in an emergency (they can be the same persons)

In the event of an emergency, illness or accident concerning my child and the teacher being unable to contact me or other persons so authorised by me, I consent to the Centre seeking on my behalf, medical, dental, hospital and ambulance attention for my child and I accept full liability for any medical, dental, hospital and ambulance expenses as may be incurred

PRIORITY OF ACCESS GUIDELINES

Under our agreement with The Australian Commonwealth Government for Childcare Benefit approval we must offer places first to parents/carers who meet the priority of access guidelines stipulated. To assist us to determine your "need" for childcare support, in accordance with this access system, please indicate the following

Whether your childcare needs are work/study related	Y / N	Disabled person in the family	Y / N
Aboriginal/Torres Strait Islander family	Y / N	Single parent	Y / N
Lower income	Y / N	Socially isolated	Y / N
Non English speaking background	Y / N		

I have read and understood the Centre Information Booklet and agree to abide by the Policies, Procedures and conditions described therein.

I consent for the use of my child's photograph in professional journals and for Centre publicity materials (no names will be given).

I understand that if I do not provide the CRN and date of birth for my child and myself I will not receive CCB discounted fees nor be entitled to the Childcare Tax Rebate.

Signed:

Date:

Office use only

Entered into Kiicare	Registration & Bond billed	ID no advised to parent	Orientation Visit conducted
			Date Sign