Calvary Christian College

A Ministry of Logan Uniting Church

OUTSIDE SCHOOL HOURS CARE
Enrolment Form 2013

ONE FORM PER CHILD

☐ **Carbrook Campus** ☐ **Springwood Campus**

FAMILY CRN:____________________________________ **(Must be listed)**

STUDENT(S) DETAILS

Surname:____ Christian Name:___________________________________ Male / Female

Date of Birth: ______________________________________Language Spoken at Home:_____________________________________

Address:____

____Home Ph:____

Child CRN: ____**(Must be listed)**

ARE THERE ANY SPECIAL INSTRUCTIONS RELATING TO THE STUDENT (please attach copy of documents)

ie: Court order / Custody arrangements / Recent bereavement / Special Diet / Cultural matters

____

____

FAMILY DETAILS:

FATHER/GUARDIAN'S NAME

____

ADDRESS(if different from child) __________________

____

PH:(hm)__________________(wk)__________________

MOBILE: _________________DOB:__________________
Employers Name___________________________________
Email: ____

MOTHER/GUARDIAN'S NAME

____

ADDRESS(if different from child)_____________________

____

PH:(hm)____________________(wk)__________________

MOBILE: _________________DOB:_________________
Employers Name____________________________________
Email: ____

Marital Status: Married / Single / Widowed / Divorced / Separated / _____________

SIBLINGS: *Please list any siblings currently attending Calvary Christian College.(list name and class) Siblings in Care* ☐

____

____

AM CARE	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
PM CARE	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**

Please circle the days for either morning (AM) or afternoon (PM) that care is required

COMENCEMENT DATE: ________________ *Please note: Your child will be enrolled for care from this date.

Please note: If your child is enrolled for a OSHC session and is absent, notification must be received by 1.00pm on the session day for after school care or 1.00pm on the day before for before school care. Failure to do so will result in the attendance being charged. Thank you for your cooperation.

Updated 14 February 2013

STATEMENT OF HEALTH

Medicare No. ______________________________ Private Health Insurance No. _______________________

<table>
<tr>
<td>
Does your child suffer from any of the following: (if yes, please attach full details, including medical report, treatment required and medication Describe what the implications may be for the student at school or on excursions)

• Chronic ailments Y / N
• Allergies Y / N
• Phobias Y / N
• Heart Problems Y / N
• Respiratory Problems* Y / N
• Diabetes Y / N
• Epilepsy Y / N
• Blood Pressure Y / N
• ADD / ADHD Y / N
• Physical disability Y / N

Has the student's hearing and vision been checked recently? Yes / No

If "yes", to any of the above, please comment.

____
____
____
(please attach further medical information if necessary)
</td>
<td>
*IF YOUR CHILD SUFFERS FROM ASTHMA:
If ventolin or other inhaler is required,
(1) Is the student able to administer it? Yes / No
(2) Do you authorise the staff of this College to offer assistance when necessary?: Yes / No

VACCINATIONS:
( ) 12 months - MMR(measles, mumps, rubella)
( ) 5 year-triple antigen (tetanus, diphtheria and whooping cough) and sabin (polio)
( ) 10 - 16 years - MMR (boys and girls)
( ) Year 10 or prior to leaving school - ATD (adult tetanus and diphtheria and oral sabin)
NB If your child has not received these vaccinations, they will be available during the school year as part of the Logan City Council Health Department school clinic service. For further details phone 3826 5365 (Logan City Council Health Department).
NB These vaccinations are recommended by the National Health and Medical Research Council of Australia

Student's doctor: ____
Phone Number: ____
Address:____
____

NOTE: Prescription medication may be administered by staff. A letter of request must be submitted in each individual situation. Medication is to be sent to OSHC in its original container with pharmaceutical instructions.
If it is a short course, please send enough for one day only.
</td>
</tr>
</table>

EMERGENCY CONTACT: ***(other than the custodial parents of the child)***

The people named below have been notified that the College may call upon them and have agreed to be available to collect my/our children from the College if I/we are unavailable.

Name:______________________________ Relationship:_______________ Phone nos.______________________

Address:____ ______________________

Name:_________________________________ Relationship:_______________ Phone Nos.______________________

Address:____ ______________________

**** It is vitally important, in the case of emergency or illness, that this section has been completed.***

I hereby authorise staff of the College to access medical attention for my child

………………………………………………………………….. ……………………………………………………

Parent Signature Date

I hereby give permission for photographs of my child to be used, displayed and shared within the Calvary Christian College Community.

………………………………………………………………….. ……………………………………………………

Parent Signature Date

The above information is collected for the primary purpose of assisting staff to fulfil their role of teaching, duty of care and administration. Calvary Christian College abides by the National Privacy Act 2001. For further information please do not hesitate to contact the College Administration

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Postal: PO Box 174, Springwood Qld 4127
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