



Brunswick South
PRIMARY SCHOOL
imparare insieme ♦ creare insieme ♦ vivere insieme

OUTSIDE SCHOOL HOURS CARE

WELCOME

Welcome to Brunswick South Primary School Out of Hours School Care (BSPS OSHC)

Our aim is to provide a fun, supportive, nurturing and secure environment where children can develop their physical, social and cognitive skills to become confident and competent individuals.

Please keep the first 2 pages of this document as a reference and return the enrolment form from page 3-9.

We take pride at BSPS OSHC in promoting freedom of expression, community values, artistic development, and independence.

PHILOSOPHY AND GOALS

Brunswick South PS OSHC:

- Provides a safe and stimulating environment for all the children who attend.
- Promotes that all children be free from prejudice or bias which may result from their gender, age, culture, race, economic background, perceived status or sexuality, or perceived behavioural issues.
- Believes in recognising and supporting all the cultures to be found within our community. Children shall be treated with care, consideration and equally whilst acknowledging difference and diversity.
- Encourages all children to contribute to program planning, structure and evaluation. All activities are negotiated by the attending group, and considered for their environmental impact.
- Provides a program that offers a wide range of play and recreational experiences, including activities that promote physical, creative and aesthetic development and the learning of life skills.
- Celebrates a culture of children who can be free of social stereotypes or perceptions, where free-thinking and individuality is valued and nurtured.
- Celebrates what unites us as a community of individuals, and what is revealed as our common human needs and wishes.

Please read the enrolment form carefully, fill it out and sign the declaration before returning it either to the OSHC office or to the school office.

Refer to the OSHC Family Handbook for further information regarding policies and procedures.

EMAIL:

ohsc.brunswick.south.ps@edumail.vic.gov.au

PHONE:

0415 234 890 or between the hours of 8:30am – 4:30pm, contact the school on 9380 1231

BOOKINGS, CANCELLATIONS AND MESSAGES:

If your child is absent, please let us know by contacting us on 0415 234 890 – Any texts, or voicemails are checked regularly. **If the matter is urgent**, please ring 9380 1231 (during school office hours – 8:30am – 4:30pm).

Please make all changes/requests for bookings either by email, text message or written into the communication book.

Please refer to the family handbook for further information on cancellations and casual bookings.

OSHC COORDINATOR – WENLI FEI (VIVIEN):

Please contact me on the above contacts if you have any enquiries regarding the program, food, activities or any general enquiries.

FEES

Before school: \$9.00 permanent bookings \$11.00 casual bookings

After School \$14.00 permanent bookings \$17.50 casual bookings

ACCOUNTS:

Statements are sent via email at the beginning of each month (unless you have requested otherwise). Payment is due within 7 days.

HOW TO MAKE A PAYMENT

At the office

- Eftpos
- Cash
- Cheque

Electronic Payment

Direct Deposit

BSB: 063 228 Acct No. 10018837

Name: Brunswick South Primary School

Enter description:

ASmith(student name)/OSHC



STUDENT ENROLMENT FORM 2017

Child A

Please PRINT clearly. All information is strictly confidential.

First Name		Family Name		<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth		Grade		Year began at BSPS
Main language spoken at home <input type="checkbox"/> English <input type="checkbox"/> Other(please specify below):			Cultural Background:	

Child B

First Name		Family Name		<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth		Grade		Year began at BSPS
Main language spoken at home <input type="checkbox"/> English <input type="checkbox"/> Other(please specify below):			Cultural Background:	

Child C

First Name		Family Name		<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth		Grade		Year began at BSPS
Main language spoken at home <input type="checkbox"/> English <input type="checkbox"/> Other(please specify below):			Cultural Background:	

OFFICE USE ONLY

Immunisation Certificate received?: (tick)	<input type="checkbox"/> Complete	<input type="checkbox"/> Not sighted
Is there a Medical Alert for the student? (tick)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Court Order	<input type="checkbox"/> Yes (attached document)	<input type="checkbox"/> No
Parenting order	<input type="checkbox"/> Yes (attached document)	<input type="checkbox"/> No
Child health record	<input type="checkbox"/> Sighted	<input type="checkbox"/> Not sighted

Days Required – Permanent Bookings

Before Care					After Care				
Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri

Parent / Guardian A (responsible for account)

Mother Father† Other†.....

First Name..... Last Name.....

Date of Birth:/...../..... **(Must be completed to receive Child Care Benefit)**

Cultural background:.....

Postal Address.....

.....Postcode.....

Address of Child(if your child’s address is different with Parent A, please specify below)

Address (Child A):

Address (Child B):

Address (Child C):

Phone No’s: Mobile..... Home ph.....

Workplace Work ph:.....

Work Address.....

Email (this will be used for billing and communication so it must be correct and printed clearly)

.....

Parent / Guardian B Mother Father Other.....

First Name..... Last Name.....

Cultural background:.....

Postal Address.....

.....Postcode.....

Mobile No. Home ph.....

Workplace Work ph:.....

Work Address.....

Email.....

It is the parent / guardian’s responsibility to inform us of any changes to this information.

Emergency Contact 1

First Name				Family Name		
Mobile No.		Work No.		Home No.		
Relationship to child/ren						

Emergency Contact 2

First Name				Family Name		
Mobile No.		Work No.		Home No.		
Relationship to child/ren						

Authorised Nominee means a person who has been given permission by a parent or family member to collect child from the education and care service or the family day care educator.

Authorised Nominee 1

First Name				Family Name		
Mobile No.		Work No.		Home No.		
Relationship to child/ren						
The person is an authorised nominee to collect child from care service (tick)				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
The person is authorised to consent to medical treatment of, or to authorise administration of medication to, the child (tick)				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
The person is authorised to authorise an educator to take the child outside the education and care service premises (tick)				<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Authorised Nominee 2

First Name				Family Name		
Mobile No.		Work No.		Home No.		
Relationship to child/ren						
The person is an authorised nominee to collect child from care service (tick)				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
The person is authorised to consent to medical treatment of, or to authorise administration of medication to, the child (tick)				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
The person is authorised to authorise an educator to take the child outside the education and care service premises (tick)				<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Are there any details of any court orders, parenting orders or parenting plans provided to the approved provider relating to powers, duties, responsibilities or authorities of any person in relation to the child or access to the child? (tick)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Copy Provided: (tick) <input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any other court orders provided to the approved provider relating to the child's residence or the child's contact with a parent or other person? (tick)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Copy Provided: (tick) <input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any court orders affecting the child? (tick)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Copy Provided: <input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there anyone legally denied access to the child?(tick)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Copy Provided: <input type="checkbox"/> Yes	<input type="checkbox"/> No

The following people are NOT authorised to collect my children:

- 1.....
- 2.....

Please arrange an appointment with the Coordinator to discuss any custody issues, court orders, other special family circumstances, emotional concerns or considerations affecting the child/ren.

Child Care Benefit (CCB) helps families with their child care costs and is paid by the **Family Assistance Office / Centrelink**. You will need a **Customer Reference Number (CRN)** for your family and your child/ren in order to receive CCB. Please call the Family Assistance Office on **13 61 50** to receive your CRNs

It is essential that all names, middle initials, CRNs and dates of birth listed above are exactly the same as what has been provided to the Family Assistance Office in order to avoid processing errors and delayed CCB payments.

Family CRN..... (ie. Parent / Guardian A)

Child **name** & CRN (A).....

Child **name** & CRN (B).....

Child **name** &CRN (C).....

Medical Information: (The following section must be filled out for each child)

CHILD (A) Name:

Child's Doctor: Phone no:.....

Clinic address:.....

Medicare No:.....

Preferred Hospital:

Do you give authority for your child to receive medical attention: *(Please circle)* Yes No

Do you have ambulance cover insurance? *(Please circle)* Yes No

Membership No.

Do you give authority for your child to be transported by ambulance: *(Please circle)* Yes No

Date of last tetanus injection:

Does your child have or had any diagnosed healthcare needs or medical conditions? (please provide details)

.....

Does your child have any allergies? (please provide details)

.....

Has your child been diagnosed as being at risk of anaphylaxis? Yes (please provide documents) No

Has your doctor developed an action plan to manage allergic reactions? Yes (please provide documents) No

Has your child/ren suffered from any of the following? (If yes, please provide details)

Mumps / Measles | Chicken Pox | Diabetes | Other infectious Diseases

.....

Does your child have any special needs or disabilities?

.....

Does your child have any special Dietary Requirements?

.....

Details of any medication being taken:

.....

*Medicine or tablets will only be administered to children by staff under written authorisation from a medical practitioner in accordance with the prescribed dosage. A **separate medication request form** is available and must be completed if the child requires medication while attending the program.*

Authorisation to obtain Emergency Medical Treatment:

I, (name) of(address)
 being parent/guardian of(child (A) name) do hereby authorise BSPS OSHC and its
 authorised agents and employees to seek urgent medical treatment for (child (A)
 name) including blood transfusions (if deemed necessary by a qualified medical practitioner) to protect him/her from
 harm. Medical treatment for the child from a registered medical practitioner, hospital or ambulance service AND
transportation of the child by an ambulance. I will accept any financial responsibility for such action.

Signed Date.....

Medical Information: (The following section must be filled out for each child)

CHILD(B) Name:

.....

Child's Doctor:

Phone no:.....

Clinic address:.....

Medicare No:

Preferred Hospital:

Do you give authority for your child to receive medical attention: (Please circle) Yes No

Do you have ambulance cover insurance? Yes No Membership No.

Do you give authority for your child to be transported by ambulance: (Please circle) Yes No

Date of last tetanus injection:

Does your child have or had any diagnosed healthcare needs of the child? (please provide details)

.....

Does your child have any allergies? (please provide details)

.....

Has your child been diagnosed as being at risk of anaphylaxis? Yes (please provide documents) No

Has your doctor developed an action plan to manage allergic reactions? Yes (please provide documents) No

Has your child/ren suffered from any of the following? (If yes, please provide details)

Mumps / Measles | Chicken Pox | Diabetes | Other infectious diseases

.....
.....

Does your child have any special needs or disabilities?

.....
.....

Does your child have any special Dietary Requirements?

.....
.....

Details of any medication being taken:

.....
.....
.....

*Medicine or tablets will only be administered to children by staff under written authorisation from a medical practitioner in accordance with the prescribed dosage. A **separate medication request form** is available and must be completed if the child requires medication while attending the program.*

Authorisation to obtain Emergency Medical Treatment:

I,..... (name) of(address)
being parent/guardian of(child (B) name) do hereby authorise BSPS OSHC and its
authorised agents and employees to seek urgent medical treatment for (child (B)
name) including blood transfusions (if deemed necessary by a qualified medical practitioner) to protect him/her from
harm. Medical treatment for the child from a registered medical practitioner, hospital or ambulance service AND
transportation of the child by an ambulance. I will accept any financial responsibility for such action.

Signed Date

PERMISSIONS

Permission for my child/ren to be photographed or videoed: <i>(Please circle)</i>	Yes	No
Permission for my child/ren to watch PG rated movies: <i>(Please circle)</i>	Yes	No
Permission for BSPS OSHC to apply sunscreen to my child/ren: <i>(Please circle)</i>	Yes	No

AGREEMENT

I agree:

1. That I will indemnify, now and in the future, Brunswick South PS Outside School Hours Care (BSPS OSHC) and its authorised employees and agents from and against all claims and demands of whatever nature and description which may be brought against BSPS OSHC directly arising out of or relating to my child’s attendance at BSPS OSHC or any activities connected with the program other than as a result of dishonesty, or negligence attributable to BSPS OSHC.
2. In the case of sudden illness or accident, BSPS OSHC has power to seek medical attention, including blood transfusion, to protect my child from harm.
3. To pay all costs of medical or ambulance attention if so required.
4. To keep my child away from BSPS OSHC, when suffering from an infectious or contagious disease.
5. To inform the OSHC staff of any absence of my child/ren, prior to session starting times, or accept penalty charges (Refer to Family Handbook: Registration and Booking).
6. That my child/ren are bound by BSPS OSHC and the Service Rules as laid down by BSPS OSHC during the period of my child’s/children’s enrolment.
7. That BSPS OSHC has the right to refuse further attendance at BSPS OSHC of children whose behaviour is harmful to the property, facilities or environment of BSPS OSHC, or to the property or person of the children and staff who attend BSPS OSHC.
8. To sign the attendance sheet, including time of collection, when collecting my child/ren from BSPS OSHC.
9. That my child/ren cannot leave BSPS OSHC with anyone other than the authorised parents/guardians or emergency contact person without prior arrangement with BSPS OSHC staff, which includes a written permission form signed by the Parent/Guardian.
10. Although I realise that every care will be taken, I agree that the staff and leaders of BSPS OSHC are free of all responsibility for lost property in connection with my child’s/children’s participation.
11. To give permission for my child/ren, to leave BSPS OSHC for excursions and trips as part of the program’s activities. That they may travel by Public Transport, private Charter Bus on excursions and private car in the case of emergency during the Outside School Hours Care Program.
12. To pay all costs incurred by my child/ren’s attendance and/or penalties that may occur as set out in the BSPS OSHC Handbook.
13. That as a parent/guardian I have read this agreement and have understood its implications for my child/ren and myself.

Parents Statement: The information given in this statement is true and correct.

Signature **Date**/...../.....

Relationship to child/ren:.....