



## South Liverpool Out of School Hours KIDSCARE INC.

62 Cabramatta Ave, Miller NSW 2168

Landline-(02) 9608 3841 Mobile-0488 041 011

[Email-shine2168frs@gmail.com](mailto:Email-shine2168frs@gmail.com) or [slooshkidscare1@gmail.com](mailto:slooshkidscare1@gmail.com)

<https://www.facebook.com/Sloosh-Kids-Care-1607028576211095/>

ABN: 61 425 407 142

## ENROLMENT FORM

for

### Vacation Care

\*\*\* You **must** answer **all questions** - please print & use a black or blue pen \*\*\*

#### PARENT / GUARDIAN 1 INFORMATION: -

Education and Care Services National Regulations - Regulation 160 (3b)

Title	Surname	First Name	D.O.B
			__ / __ / __

Relationship to Child	Are you of Aboriginal or Torres Strait Islander Descent?
	Please Confirm:

Address:			
	State		Postcode
Home Phone:		Mobile Phone	
Email:			
Main language spoken at home? English <input type="checkbox"/> Other <input type="checkbox"/> Please Specify:			

Employer:	Work Phone
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Parent/Guardian1 CRN: _ _ _ _ _	Is this Parent/Guardian1 Linked to Childcare Subsidy - Yes/No (Circle)
Does your child have siblings, if yes please advise their names and ages?	

\*\*\*Customer Reference Number - CRN Number is a mandatory requirement, Centrelink\*\*\*

\*\*\*Please provide your Childs Birth Certificate\*\*\*

PARENT / <b>GUARDIAN 2</b> INFORMATION: -
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Education and Care Services National Regulations - Regulation 160 (3b)

Title	Surname	First Name	D.O.B
			__ / __ / __

Relationship to Child      Are you of Aboriginal or Torres Strait Islander Descent?

	Please Confirm:
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**Address:**

	State		Postcode	
Home Phone:		Mobile Phone		
Email:				
Main language spoken at home?   English <input type="checkbox"/> Other <input type="checkbox"/> <b>Please Specify:</b>				

**Employer:**

	Work Phone	
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Parent/Guardian2

CRN: \_ \_ \_ \_ \_

Is this Parent/Guardian2 Linked to Childcare Subsidy -

Yes/No **(Circle)**

**Emergency Contact Details:**

Education and Care Services National Regulations 160(3b, ii,iii,iv,v) 161(1a,I,ii,1b).

In case of emergency, please provide the names of the persons we can contact.

(Other than parents or guardians)

Contact 1		Phone:	
Contact 2		Phone:	

Doctor Name		Phone:	
Medicare No:		Ambulance cover	Yes/No <b>(Circle)</b>
Private Health Insurance Name:		Private Health Insurance Number:	

In the event of the parent / guardian or nominated persons being uncontactable, would you accept our arrangements, for emergency treatment, medical, hospital or ambulance? **Yes / No (Circle)**

Can this person/consent to the Nomination Supervisor or an educator taking the child outside the service if we cannot contact you? **Contact 1 - Yes / No (Circle) Contact 2 - Yes / No (Circle)**

I authorise this person to collect my child from this service: **Yes / No (Circle)** Can this person consent to medical treatment or the administration of medication if you are not contactable?

**Contact 1 Yes / No (Circle) Contact 2 Yes / No (Circle)**

Signature of Parent / Guardian1: \_\_\_\_\_ Date: \_\_ / \_\_ / \_\_

Signature of Parent / Guardian2: \_\_\_\_\_ Date: \_\_ / \_\_ / \_\_

## CHILD'S INFORMATION

Please Note: You will need to fill in a separate form for each child.

Child's Surname		First Name	
Child's CRN	_ _ _ _ _		
Is this child of Aboriginal or Torres Strait Islander			Yes / No (Circle)
D.O.B	--/--/--	1 <sup>st</sup> day at this centre	--/--/--
		1 <sup>st</sup> day at school	--/--/--

Religion/Culture	
Interests and Hobbies: -	

Please ensure that all your details are up to date and active with **CENTRELINK** to be eligible to receive **SUBSIDISED CARE**.

If we don't receive the **required information** from **CENTRELINK** we will have, **NO ALTERNATIVE**, but to charge you the **FULL RATE** for any care provided.

## CHILD'S MEDICAL INFORMATION

Doctors Name:	Doctors Contact Number:
Doctors Address:	
Medicare Number:	
Private Health Fund: Yes / No (Circle) Ambulance Cover: Yes / No (Circle)	

## IMMUNISATION

Education and Care Services National Regulations - Regulation 160 (3a, I, j)

Are Immunisation Records completely up to date?	Yes / No (Circle)
Please attach an Immunisation History Statement:	Attached: Yes / No (Circle)
Are there any health concerns or allergies? If so, please detail below.	
Any Medication Requirements: Yes / No (Circle) discuss Plan / Requirements.	

Copy of your child(ren) Immunisation forms can be retrieved through your MyGov account or alternatively made by contacting 1800 653 809 / by emailing to the following email address [acir@medicareaustralia.gov.au](mailto:acir@medicareaustralia.gov.au).

If your child(ren) Immunisations are not up to date the centre requires the following documents to be provided before enrolment can be accepted.

- A current ACIR Immunisation history form on which the child's doctor has signed and certified that the child is on an approved catch-up schedule.

ACIR Immunisation History Form Received:	Yes <input type="checkbox"/>
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- An ACIR Immunisation exemption - Medical Contradiction Form signed by a doctor.

Medical Contradiction Form Received:	Yes <input type="checkbox"/>
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## IMMUNISATION HEALTH

Does your child suffer from any Allergies?	Yes / No (Circle)
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If yes, please provide clear details of your child's allergies, any side effects that are known, specify any treatments and action plans in place or provided by a doctor.

Action plan discussed with Parent / Custodian. Yes ☐

Copy of Action Plan received. Yes ☐

Does your child have a diagnosed disability or any special needs?	Yes / No (Circle)
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If yes, please provide clear details of your child's disability / needs, provide any applicable medical documentation that will assist the centre with the appropriate care management plan.

Disability / needs discussed with Parent / Custodian. Yes ☐

Copy of any medical documentation. Yes ☐

In the event of an accident or illness requiring medical treatment, or Panadol / Nurofen/Claritin every effort will be made to contact parents before such treatment takes place. However, on the chance that this should prove impossible, it is necessary for authority to be given in advance.

I \_\_\_\_\_, the undersigned give permission for the staff of SLOOSH KIDSCARE to seek medical / ambulance attention for my child / children under their care, in the event of an accident or emergency and I agree to pay such costs as may be incurred.

Signature of Parent / Guardian \_\_\_\_\_ Date \_\_/\_\_/\_\_

## BOOKINGS FOR VACATION CARE – which days do you require care?

(Please tick below)

Days of the week required	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1 Vacation Care	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Week 2 Vacation Care	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Week 3 Vacation Care	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Week 4 Vacation Care	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

Please provide us with any other information we should know about your child: (e.g., favourite activity, favourite food, strengths, or sports).

Are there any restrictions, custody or access matters that would affect who can pick up your child/ren such as court orders? Yes / No (Please Circle)

Please give details and attach relevant documents:

Documents Provided Yes ☐

Does your child take prescribed medication? or treatment on a regular basis?	YES/NO (Please Circle)	If so, please detail below and seek a medication form from staff.
Does your child suffer from anaphylaxis?	YES/NO (Please Circle)	If so, please detail below
Does your child suffer from asthma?	YES/NO (Please Circle)	If so, please detail below:
Does your child have any special dietary or cultural restrictions?	YES/NO (Please Circle)	If so, please detail below:
Does your child have any other specific health needs (E.g., Diabetes)?		

Please Complete with the Nominated Supervisor/Responsible Person a Medical Conditions Risk Minimisation Plan to attach to this enrolment.

**PLEASE ensure you have filled out all information regarding your child.**

In the event of an accident or illness requiring medical treatment, or

Panadol/Nurofen/Claritin to be administered every effort will be made to contact parents/carer before such treatment takes place. However, on the chance that this should prove impossible, it is necessary for authority to be given in advance. I

\_\_\_\_\_ the undersigned give permission for the staff of SLOOSH KIDSCARE to seek medical/ambulance attention for my child / children under their care, in the event of an accident or emergency and I agree to pay such costs as may be incurred.

Signature of Parent/Guardian \_\_\_\_\_ Date\_\_\_\_\_

## **Transportation:**

I \_\_\_\_\_ give permission for my child/ren to travel in the minivan provided by SLOOSH KIDSCARE between the centre and the local schools. I understand that, if the van is unavailable for any reason, the SLOOSH KIDSCARE will provide alternative transport, usually by taxi.

I will pay only for the SLOOSH KIDSCARE transport fare, not the taxi fare.

In giving my permission, I understand that the SLOOSH KIDSCARE, its staff & management, will undertake every reasonable care and precaution for the safety and wellbeing of the children travelling, however, they will not be held responsible for accidents or other events which may occur, and which are beyond their control.

Signature of Parent /Guardian\_\_\_\_\_

Date\_\_\_\_\_

## **Additional Home Transport**

If you require a pickup or drop off service for before or after school care, the cost will be \$5.00 each way per child.

To access this service, you must fall within our transport service area. Please speak to management to see if you are eligible for this service.

Please tick ☒ the days when transport is required.

	WK	Monday	Tuesday	Wednesday	Thursday	Friday	Total Cost
Morning	1	Yes	Yes	Yes	Yes	Yes	
Afternoon	1	Yes	Yes	Yes	Yes	Yes	
Morning	2	Yes	Yes	Yes	Yes	Yes	
Afternoon	2	Yes	Yes	Yes	Yes	Yes	
Morning	3	Yes	Yes	Yes	Yes	Yes	
Afternoon	3	Yes	Yes	Yes	Yes	Yes	
Morning	4	Yes	Yes	Yes	Yes	Yes	
Afternoon	4	Yes	Yes	Yes	Yes	Yes	

Please circle days required.

**Swimming**

I \_\_\_\_\_ give permission for my child/ren to go for a spontaneous swim if weather and staff ratios permit this.

Please Circle Your Child's Swimming Ability:      Poor      Average      Good

**Excursions**

I \_\_\_\_\_ give permission for my child/ren to go for a spontaneous excursion if the weather and staff ratios permit this. Parents/Guardians will be contacted prior to this excursion taking place if their child will be participating by various forms of communication such as: SLOOSH Facebook page, Verbal, Communication Book, Email, Phone or Text.

I also understand that Risk Assessments will be conducted prior to the excursion occurring and will be evaluated at completion.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Photo/Social Media Permission:**

I \_\_\_\_\_ DO/DO NOT give staff permission for my child's image/photograph to be used on SLOOSH KIDCARE Facebook page, website, and other related community social media events.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Sunscreen/Hand Sanitiser**

I \_\_\_\_\_ DO/DO Not give staff permission to apply SPF30+ (or higher) broad-spectrum water-resistant sunscreen and Hand Sanitiser.

**Fees Policy:**

We aim to provide quality service that is affordable. Fee levels will be set by management each year on completion of an annual budget and according to the centres required income.

Fees are reviewed annually, based on attendance and the centre's ability to meet the running costs.

Parents/caregivers will be given at least 2 weeks' notice of any changes in the fees.

Fees must be paid weekly or fortnightly and must be paid in full by the end of each vacation care period. Casual and emergency care must be paid for on the day of care.

Fees are to be paid for the days the child is booked into the centre, including times when the child is absent due to illness or holidays and for public holidays.

CCB is paid for sick days and up to 42 days allowable absences per session per year, and for public holidays.



2 weeks prior notice in writing is to be given to the Co-ordinator for any changes to the days of care or cancellation of care. If no notice is given, bookings will still be charged.

I have read and understood the information above.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

#### Late Fee:

I understand that a late fee of \$15.00+ CST will be charged for each 15minutes, after closing time, of 6pm and that continued lateness after three warnings may result in the cancellation of my child's placement.

I have read and understood the information above.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

ALL FEES ARE PAYABLE WEEKLY BY BANK TRANSFER
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### **Privacy Notice**

Personal information will be managed openly and transparently in a way that protects an individual's privacy and respects their rights under Australian privacy laws.

We only collect or use personal information if this is needed to education and care to children at the service, or to comply with our legal obligations. We will take reasonable steps to make sure you know we have your personal information, how we got it and how we'll handle it.

We collect most personal information directly from a parent or guardian. We may also collect information through our website, social media page, Family Law court orders or agreements, special needs agencies and training courses. We may occasionally request information from other organisations which you would reasonably agree is necessary for us to educate and care for a child.

The information collected includes information required under the National Education and Care Law and Regulations or needed to promote learning under the Early Years Learning Framework. This includes name, address, date of birth, gender, family contact details, emergency contact details, authorised nominee details, parents' occupations, cultural background, home language, religious beliefs, payment details, childcare benefit information, Medicare number, immunisation records, medical information and medical management plans, photos of children and information about children's strengths, interests, preferences and needs, including special needs. We do not disclose personal information to others unless you would reasonably expect us to do this, we have your consent, or we are complying with an Australian law.

We aim to keep the personal information we hold accurate, up-to-date, and complete. This enables us to provide high quality education and care while ensuring the health and safety of children, and it is also important that we can contact you in the event of an emergency.

We have systems and practices in place to ensure personal information is secure and can only be accessed by those who need the information or may legally access it. You have the right to access your personal information. There are some circumstances under Australian privacy laws where we may not be able to give you access. We will tell you if this is the case. There is generally no cost for accessing your information. We will tell you if there is a charge before providing access.

Our Privacy Officer for privacy matters, including complaints, is the Approved Provider or Nominated Supervisor who may be contacted by telephone on 0488 041 011 NUMBER or email [slooshkidscare1@gmail.com](mailto:slooshkidscare1@gmail.com) or by mail 62 Cabramatta Ave Miller NSW 2168. We will provide a copy of any updates to our Privacy and Confidentiality Policy on our Service Noticeboard and include the changes in our Newsletter.

### **DECLARATION**

As a person who has parental responsibility for the child referred to in this enrolment form for SLOOSH KIDSCARE I declare that the information in this enrolment form is true and correct and I will immediately inform the service in the event of any change to this information, I understand there may be costs involved in the provision of professional medical, ambulance or hospital services for my child/ren as a result of a medical emergency or accident at the service, and I agree to pay those costs.

I agree to collect or plan for the collection of my child if he/she becomes sick/unwell. I will not send my child to the service if he/she is sick/unwell at the service. I understand my child must have any required medication (always including EpiPen) with them at the service or they will be unable to attend.

I understand and agree that a first aid trained staff member may administer first aid when necessary.

I declare that I have read and understood the Code of Conduct and policies of SLOOSH KIDSCARE and will abide by them.

These policies include the Medical Conditions Policy, Administration of Authorised Medication Policy, Delivery and Collection of Children Policy, Infectious Disease Policy, Immunisation Policy, Behaviour Guidance Policy (in Relationships with Children Policy) and Privacy and Confidentiality Policy.

I have read and will comply with the fees and payment structure of SLOOSH KIDSCARE, I agree to update any information relating to my emergency contacts, the people I have authorised to collect my child, and my child's medical or dental professionals (including their contact details).

I agree to provide updated information about my child's immunisations whenever he or she is vaccinated I agree that my child's place at the service is subject to the Priority of Access scheme as outlined in the Enrolment Policy. I agree for my child to be observed and programmed for by students who may be employed at the service or completing practical components of their studies at the service, and if relevant, copies of the child's documentation to be submitted to the institution the student is completing their studies at as part of an assessment.

I agree to provide information about my child's life, family and community to support the achievement of meaningful learning outcomes.

I understand that the Nominated Supervisor may suspend or terminate my child's place at the service if he/she feels that the safety or wellbeing of any child or staff

member at the service is compromised by my child or a family member. We aim to provide quality service that is affordable.

I have read and understand the information above.

Print Name of Parent/Guardian\_\_\_\_\_Date\_\_\_\_\_

Signature of Parent/Guardian\_\_\_\_\_Date\_\_\_\_\_

Print Name of Authorised Witness\_\_\_\_\_Date\_\_\_\_\_

Signature of Authorised Witness\_\_\_\_\_Date\_\_\_\_\_

