ST MARY'S COLLEGE

OUT OF SCHOOL HOURS CARE

ENROLMENT FORM

Submit form to: aevans@stmaryscollege.catholic.edu.au or oshc@stmaryscollege.catholic.edu.au OR call OSHC direct phone number on 8216 5743 for assistance

STUDENT SURNAME: ______________________ STUDENT FIRST NAME/S: ______________________

ADDRESS: ____

DATE OF BIRTH: ____ / ____ / ____ CLASS: ________

STUDENT'S C.R.N (CARER'S REF. NUMBER): ______________________________

PARENTS CLAIMING CHILD CARE REBATE INFORMATION

PARENT'S C.R.N: ______________________________________

MOTHER'S DATE OF BIRTH: ____ / ____ / ____ FATHER'S DATE OF BIRTH: ____ / ____ / ____

STUDENT LIVES WITH (Please tick): ONE PARENT [ ] BOTH PARENTS [ ]

GUARDIAN/ MOTHER'S FULL NAME: ____

ADDRESS: ____

HOME PHONE: ______________________________________

MOBILE PHONE: ______________________________________

WORK PHONE: ______________________________________

EMAIL ADDRESS: ____

GUARDIAN 2 / FATHER'S FULL NAME: ____

ADDRESS: ____

HOME PHONE: ______________________________________

MOBILE PHONE: ______________________________________

WORK PHONE: ______________________________________

EMAIL ADDRESS: ____

253 Franklin Street, Adelaide, SA 5000
Tel 08 8216 5700 Fax 08 8216 5730
accounts@stmaryscollege.catholic.edu.au
www.stmaryscollege.catholic.edu.au

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If anyone is denied access to the student, please state details below:

NAME: ______________________________ RELATIONSHIP TO STUDENT: ___________________

COMMENTS: ____

____

____

EMERGENCY CONTACT DETAILS

SURNAME: ______________________________ FIRST NAME: ______________________________

RELATIONSHIP TO STUDENT: ______________________________

PHONE NUMBER: ______________________________

People other than Parent's who are authorised to collect student:

1. FULL NAME: ______________________________________ PHONE NUMBER _________________
2. FULL NAME: ______________________________________ PHONE NUMBER _________________

ATTENDANCE DAYS REQUIRED

DAYS REQUIRED

Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ]

Please indicate approximately how long your child will remain each day

Times: [ ] to 4:00pm [ ] to 5:00pm [ ] to 6:00pm

STUDENT MEDICAL INFORMATION

Please give FULL details of the following:

1. Physical limitations or medical conditions:
   Any prescribed or other medication, giving name of medication, when to be taken, etc
   ____
   ____
   ____
2. Any known allergies (including food allergies):
   ____
   ____
3. Any other problems you feel staff should be aware of:
   ____
   ____

ST MARY'S COLLEGE

4. Medicare Number: ___________________________________

5. Doctor's Name: ___________________________________
Doctor's Phone Number: ___________________________________
Doctor's Address: ____

In case of an emergency, every effort will be made to contact parents prior to taking action or seeking treatment.

CONSENT

If my child should require medical treatment, I authorise staff to obtain any medical assistance which they deem necessary, and I agree to pay all medical and transport costs incurred on behalf of my child.

I further authorise qualified practitioners to administer anaesthetic if needed.

I realise that while all care is taken with my child/ children while at the centre, the staff cannot be held responsible for any accident that might occur.

SIGNATURE GUARDIAN/ MOTHER: ___________________________________ DATE: _____ / _____ / _____

SIGNATURE GUARDIAN 2/ FATHER: ___________________________________ DATE: _____ / _____ / _____