ABCC ENROLMENT FORM 2017

CHILD'S NAME:
Office use only: Date entered:_____By: Enrolment Type: Form / Inform / AMEP /Other

PLEASE COMPLETE A SEPARATE FORM FOR EACH CHILD, ATTENDING EITHER ST JOHN'S ANGLICAN COLLEGE OR ST JOHN'S EY ABCC. ALL SECTIONS MUST BE COMPLETED. ANY SECTION NOT COMPLETED WILL MEAN THE FORM IS RETURNED AND MAY CAUSE A DELAY IN YOUR CHILD'S COMMENCEMENT DATE AT ABCC.

PRIVACY:
The College adheres to the Australian Privacy Principles as set out in the Privacy Act (Cth) 1988. Further details are available in the College's Privacy Procedure located on the College's website.

CHILD'S DETAILS:

CHILDS NAME:							
HOME ADDRESS:							
DOB:		☐ *MALE*	☐ *FEMALE*	*CLASS:*		*COUNTRY OF BIRTH*	
CHILD'S CRN:		*FAMILY CRN HOLDER (FOR THISCHILD):*			☐ *MOTHER*	☐ *FATHER*	
ARE THERE ANY PARENTING ORDERS RELATING TO YOURCHILD?					☐ *NO*	☐ *YES*	
HAVE COPIES OF THE RELEVANT DOCUMENTATION BEENPROVIDED?					☐ *NO*	☐ *YES*	

RELEVANT DOCUMENTATION MAY INCLUDE PARENTING PLANS, PARENTAL RESPONSIBILITY PLANS, RESIDENCE ORDERS AND CONTACT ORDERS.

PARENT/GUARDIAN DETAILS:

PARENT /GUARDIAN 1 –ACCOUNT HOLDER

				EMAIL ADDRESS:			
NAME:							
HOME ADDRESS:							
DOB:		☐ *MALE*	☐ *FEMALE*	*COUNTRY OF BIRTH:*		*RELATION TO CHILD:*	
Phone:	Home		Mobile		Work		
FAMILY CRN:			*NO OF CHILDREN IN CARE (INCLUDING CHILD STATED ABOVE):*				
WORK STATUS:	☐ NOT APPLICABLE		☐ WORK > THAN 15HOURS PER WEEK		☐ LOOKING FOR WORK		
	☐ STUDYING/TRAINING		☐ DISABILITY / DISABILITY CARER				
OCCUPATION:			*WORKPLACE SUBURB:*				

THE DATE OF BIRTH AND CENTRELINK REFERENCE NUMBERS (CRN) FOR THE ACCOUNT HOLDER AND EACH CHILD ARE REQUIRED FOR THE PURPOSES OF LINKING FOR CHILD CARE BENEFITS (CCB) AND THE 50% CHILD CARE REBATE. FAMILIES MUST BE ASSESSED AS ELIGIBLE FOR CCB, PLEASE CONTACT THE DHS ON 136150 FOR FURTHER INFORMATION.

PARENT /GUARDIAN 2

				EMAIL ADDRESS (IF DUPLICATE STATEMENT REQUIRED):			
NAME:							
HOME ADDRESS:							
DOB:		☐ *MALE*	☐ *FEMALE*	*COUNTRY OF BIRTH:*		*RELATION TO CHILD:*	
Phone:	Home		Mobile		Work		
FAMILY CRN:			*NO OF CHILDREN IN CARE (INCLUDING CHILD STATED ABOVE:*				
WORK STATUS:	☐ NOT APPLICABLE		☐ WORK > THAN 15HOURS PER WEEK		☐ LOOKING FOR WORK		
	☐ STUDYING/TRAINING		☐ DISABILITY / DISABILITY CARER				
OCCUPATION:			*WORKPLACE SUBURB:*				

AUTHORISED NOMINEE / EMERGENCY CONTACT DETAILS:

Please list the details of all persons, other than parents/guardians nominated in Section 2, who are authorized to collect your child and/or can be contacted in case of emergency. We require, at least, one emergency contact person who is able to authorize emergency medical treatment or collect child.

Authorised Contact 3

Name:		
Address:		
Phone	***Mobile:***	
	Home:	
	Work:	
Relationship to child:		
Able to Collect child:		☐ Yes ☐ No
Emergency Contact:		☐ Yes ☐ No

Authorised Contact 4

Name:		
Address:		
Phone	***Mobile:***	
	Home:	
	Work:	
Relationship to child:		
Able to Collect child:		☐ Yes ☐ No
Emergency Contact:		☐ Yes ☐ No

HEALTH/MEDICAL DETAILS

DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS?:		☐ Yes ☐ No
IF YES, PROVIDE DETAILS:		
DOES YOUR CHILD REQUIRE REGULAR MEDICATION?:		☐ Yes ☐ No

IF STAFF WILL BE REQUIRED TO ADMINISTER MEDICATION, A SEPARATE MEDICATION AUTHORITY FORM IS TO BE COMPLETED BY THE PARENT/GUARDIAN. ALL MEDICATION IS TO BE PROVIDED IN ORIGINAL PACKAGING WITH THE CHILD'S NAME AND DOSAGE.

DOES YOUR CHILD HAVE ANY ALLERGIES ?:		☐ Yes ☐ No	
IF YES, PROVIDE DETAILS:		☐ Mild ☐ Severe ☐ Anaphylaxis	
IF ANAPHYLAXIS, DOCUMENT / MEDICATION SUPPLIED: ***ACTION PLAN VALID FOR 1 YEAR FROM ISSUE***	☐ Anaphylaxis Action Plan Expiry Date:	☐ EPI Pen Expiry Date:	☐ Other Medication Name: Expiry Date:

PLEASE PROVIDE ALLERGY MANAGEMENT PLAN RELATING TO YOUR CHILD.

DOES YOUR CHILD HAVE ANY ALLERGIES ?:		☐ Yes ☐ No	
IF YES, PROVIDE DETAILS:		☐ Mild ☐ Severe ☐ Anaphylaxis	
ASTHMA DOCUMENT / MEDICATION SUPPLIED: ***ACTION PLAN VALID FOR 1 YEAR FROM ISSUE***	☐ Asthma Action Plan Expiry Date:	☐ Ventolin (ABCC) Expiry Date:	☐ Ventolin College has given permission for child to carry and self-medicate.

PLEASE PROVIDE ALLERGY MANAGEMENT PLAN RELATING TO YOUR CHILD.

IMMUNIZATION INFORMATION

IS YOUR CHILD'S IMMUNIZATION STATUS UP TO DATE?	☐ Yes ☐ No
DATE OF LAST TETANUS INJECTION?	

FAILURE TO MAINTAIN IMMUNIZATIONS IN LINE WITH SCHEDULE WILL AFFECT YOUR CHILD CARE BENEFIT OR CHILD CARE REBATE ELIGIBILITY.

13vPCV	☐ Yes ☐ No	***Hep B***	☐ Yes ☐ No	***MenCCV***	☐ Yes ☐ No
23vPPV	☐ Yes ☐ No	***Hib***	☐ Yes ☐ No	***OPV/IPV***	☐ Yes ☐ No
DTPa	☐ Yes ☐ No	***Influenza***	☐ Yes ☐ No	***Rotavirus***	☐ Yes ☐ No
Hep A	☐ Yes ☐ No	***MMR***	☐ Yes ☐ No	***VZV***	☐ Yes ☐ No

DOES YOUR CHILD HAVE ANY SPECIFIC DIETARY REQUIREMENTS?:	☐ Yes	☐ No
DOES YOUR CHILD HAVE ANY FOOD INTOLERANCES?:	☐ Yes	☐ No
IF YES, PROVIDE DETAILS:		
IF YES, IS THE INTOLERANCE/ALLERGY LIFE THREATENING?:	☐ Yes	☐ No
FOOD INTOLERANCE/ALLERGY MANAGEMENT PLAN SUPPLIED: *MANAGEMENT PLAN VALID FOR 1 YEAR FROM ISSUE*	☐ Yes	☐ No

IF YOU HAVE ANSWERED YES TO ANY QUESTIONS IN SECTION 4 (EXCLUDING IMMUNIZATION INFORMATION), PLEASE COMPLETE SECTION BELOW ONLY ON RECEIPT OF DOCUMENTS FROM ABCC STAFF.

MEDICAL CONDITION ADDENDUM

THIS SECTION NEEDS TO BE SIGNED ON RECEIPT OF POLICIES 2.1, 2.2 & 2.3 AND IN THE PRESENCE OF A COLLEGE STAFF MEMBER.

If this enrolment form contains any YES answers in the Health & Medical Details Section, then the Nominated Supervisor must ensure families receive the following information and that parent/guardians have read and understood the following information by signing and dating:

PARENT / GUARDIAN:

NAME:		*SIGNED:*		*DATE:*	

☐ I have received a copy of the following ABCC Policies and Procedure documents

2.2 Medical Conditions Policy **2.3** Administering Medication Policy **2.4** Anaphylaxis and Other Medical Issues Management Plan

WITNESS:

NAME:		*SIGNED:*		*DATE:*	

MEDICAL PRACTITIONER DETAILS (MINIMUM ONE REQUIRED)

Doctor 1

NAME:	
SURGERY NAME:	
ADDRESS:	
PHONE:	

Doctor 2

NAME:	
SURGERY NAME:	
ADDRESS:	
PHONE:	

FAMILY MEDICARE NO:	

ADDITIONAL INFORMATION

DOES YOUR CHILD HAVE ANY RELIGIOUS/CULTURAL NEEDS?	☐ Yes	☐ No
IF YES, PROVIDE DETAILS:		
DOES YOUR CHILD HAVE ANY DISLIKES, FEARS OR PHOBIAS?:	☐ Yes	☐ No
IF YES, PROVIDE DETAILS:		
IS YOUR CHILD OF ABORIGINAL OR TORRES STRAIT ISLANDER DESCENT?:	☐ Yes	☐ No
IS YOUR CHILD FROM A NON-ENGLISH SPEAKING BACKGROUND?:	☐ Yes	☐ No
IF YES, NATIONALITY:		
WOULD YOU LIKE INFORMATION FROM GOVERNMENT REGULATORS OR ADDITIONAL ABCC INFORMATION?:	☐ Yes	☐ No
IF POSSIBLE, DO YOU REQUIRE A LANGUAGE OTHER THAN ENGLISH?:	☐ Yes	☐ No

BOOKING REQUIREMENTS

Families with permanent weekly bookings, complete Week 1 only. Families with fortnightly bookings (including Little Saints children attending 5 days per fortnight) complete both Week 1 and Week 2, as required.

PERMANENT DAYS: ***BEFORE SCHOOL CARE***

WEEK 1	***START DATE:***	☐ Mon	☐ Tues	☐ Wed	☐ Thurs	☐ Fri
WEEK 2	***START DATE:***	☐ Mon	☐ Tues	☐ Wed	☐ Thurs	☐ Fri

PERMANENT DAYS: ***AFTER SCHOOL CARE***

WEEK 1	***START DATE:***	☐ Mon	☐ Tues	☐ Wed	☐ Thurs	☐ Fri
WEEK 2	***START DATE:***	☐ Mon	☐ Tues	☐ Wed	☐ Thurs	☐ Fri

CASUAL CARE: ☐

Vacation Care programs and booking forms are available at least 2 weeks before the vacation care period starts. The program has a mix of in-house activities and excursion days.

Bookings are essential by returning the booking form, available on the College Website. Cancellations for booked days must have 48 hours' notice or the fee for that session will be charged. If an activity has been scheduled on a day where care was booked, and then cancelled, any charge levied by the Activity Supplier will be applied to the family's account.

PERMISSION & AGREEMENT DETAILS

This pertains to your child's continued attendance at ABCC so take the time to read before you continue.
(Please tick the appropriate boxes and initial beside each to signal your agreement)

☐	I give my consent to the information contained in this document being available to the Educators employed to work with my child in the ABCC Program. I understand this information will be handled strictly in accordance with Privacy and Confidentiality Guidelines and will only be shared as a way of improving the quality of service provision to my child.
☐	I agree to notify the Nominated Supervisor, in writing, of any change in circumstances from the details as outlined in this enrolment form, including contact details and living arrangements of my child and/or parent/guardian.
☐	I understand that it is my responsibility to ensure all Child Care Benefit requirements are fulfilled, in particular, ensuring eligibility for CCB, providing my/our date of birth and providing family and child Customer Reference Numbers.
☐	I agree to inform the Nominated Supervisor of any absence of my child as soon as possible and to pay any fee that may be incurred as a result of not cancelling within the specified timeframes, as set out in the service policy.
☐	I understand that the nature of the activities will include, but is not limited to, centre based activities/community outings/meal times and that risk may arise during these activities. I understand that I will receive a separate permission form for any excursions.
☐	I agree to pay for all fees (including excursion costs) of the days that my child attends the program. I understand that 48 hours' notice of non-attendance must be given otherwise I will be liable for, and charged, for the booked sessions.
☐	I authorize ABCC staff to provide any required first aid and to facilitate medical attention in the event of an emergency. I give permission for ABCC staff to obtain any medical, hospital and ambulance service in the case of an accident or emergency involving my child and I accept responsibility for payment of all expenses associated with such treatment. I understand that every effort will be made to contact me in the event of any illness or accident.
☐	I authorize ABCC staff to liaise with other health/medical professionals in relation to the care of my child if required.
☐	I agree to keep my child from attending the program should he/she be experiencing any illness or contagious disease.
☐	I give permission for ABCC staff to assist my child to apply a SPF 30+ sunscreen prior to outdoor activities **OR BELOW**
☐	I will supply my own sunscreen for my child to apply a SPF 30+ sunscreen prior to outdoor activities
☐	I give permission for staff to take photos of my child to record important events and special activities as part of the program. I understand that these photos will be displayed for the families to see (including on St John's Anglican College ABCC website – families only access) and will also be used for the purposes of programming and evaluation.
☐	I understand that should my child's behaviour be unable to be supported by staff, that I will be contacted and asked to collect my child.
☐	I agree to receive promotional material, programs, newsletters and/or account statements via email.
☐	I agree to adhere to the ABCC Policies and Procedures, as outlined in the ABCC Family Handbook

PARENT/GUARDIAN 1:

NAME:		***SIGNED:***		***DATE:***	

PARENT/GUARDIAN 2:

NAME:		***SIGNED:***		***DATE:***	

KINDERGARTEN EXCURSION FORM – LITTLE SAINTS PARENTS ONLY TO COMPLETE

During Term time and Vacation Care St John's Early Years ABCC may program activities outside the Kindergarten area but still within the precinct of Alpine Campus.

The areas which could be visited include:

PLAYGROUNDS	***OVAL***	***TENNIS COURTS***
UNDER COVERED AREA	***PRIMARY ABCC ROOMS***	***COLLEGE CHAPEL***

I, _____, the parent/guardian of _____ give permission for my child to participate in activities to be programmed outside the Little Saints Kindergarten area but inside the St John's Anglican College Alpine Campus precinct during Term time and the Vacation Care periods.

NAME:		***SIGNED:***		***DATE:***	

ACCOUNT NAME:

ABCC Credit Card Authorisation Form

Please complete and return to ABCC to allow fortnightly Permanent Term (Before & After School Care only) payments to be deducted from your credit card.

I, _____, authorise St John's Anglican College ABCC, to process payment of my ABCC fees asper the schedule
below.

Signature:_____

Email address:_____

Name on Credit Card:_____

Credit Card No: ____ ____ ____ ____ / ____ ____ ____ ____ / ____ ____ ____ ____ / ____ ____ ____ ____

Expiry Date:_____/ _____ CCV No: _____ ____ ____ Amount:____$_____/ fortnight_

Term 1

Date	Amount	Receipt	Processed by
7/2/17			
21/2/17			
7/3/17			
21/3/17			
4/4/17			

Term 2

Date	Amount	Receipt	Processed by
2/5/17			
16/5/17			
30/5/17			
13/6/17			
27/6/17			

Term 3

Date	Amount	Receipt	Processed by
25/7/17			
8/8/17			
22/8/17			
5/9/17			
19/9/17			

Term 4

Date	Amount	Receipt	Processed by
17/10/17			
31/10/17			
14/11/17			
28/11/17			
5/12/17*			

- To Finalise Term Payments for 2017

Office Only
Quote supplied ☐ Date___/___/___ by_____

ACCOUNT NAME:

ABCC Credit Card Authorisation Form – Vacation Care

Please complete and return to ABCC to allow Vacation Care payments to be deducted from your credit card. Payments will be deducted as per the Vacation Care Booking Form payment due dates.

I, _____, authorise St John's Anglican College ABCC, to process payment of my ABCC fees as per the schedule below.

Signature:_____

Email address:_____

Name on Credit Card:_____

Credit Card No: ____ ____ ____ ____ / ____ ____ ____ ____ / ____ ____ ____ ____ / ____ ____ ____ ____

Expiry Date:_____/ _____ CCV No: _____ ____ ____ Amount:____$_____/ fortnight_

Term 1

Date	Amount	Receipt	Processed by
28/3/17			
4/4/17			
11/4/17			

Term 2

Date	Amount	Receipt	Processed by
13/6/17			
20/6/17			
27/6/17			
4/7/17			

Term 3

Date	Amount	Receipt	Processed by
12/9/17			
19/9/17			

Term 4

Date	Amount	Receipt	Processed by
28/11/17			
5/12/17			
12/12/17			
21/12/17			
2/1/18			
9/1/18			