

ABCC ENROLMENT FORM 2018



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:		<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	CLASS:		COUNTRY OF BIRTH	
CHILD'S CRN:		FAMILY CRN HOLDER (FOR THISCHILD):		<input type="checkbox"/> MOTHER	<input type="checkbox"/> FATHER		
ARE THERE ANY PARENTING ORDERS RELATING TO YOURCHILD?				<input type="checkbox"/> No	<input type="checkbox"/> Yes		
HAVE COPIES OF THE RELEVANT DOCUMENTATION BEENPROVIDED?				<input type="checkbox"/> No	<input type="checkbox"/> 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:		<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	COUNTRY OF BIRTH:		RELATION TO CHILD:	
Phone:	Home	Mobile			Work		
FAMILY CRN:		NO OF CHILDREN IN CARE (INCLUDING CHILD STATED ABOVE):					
WORK STATUS:	<input type="checkbox"/> NOT APPLICABLE		<input type="checkbox"/> WORK > THAN 15 HOURS PER WEEK		<input type="checkbox"/> LOOKING FOR WORK		
	<input type="checkbox"/> STUDYING/TRAINING		<input type="checkbox"/> 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:		<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	COUNTRY OF BIRTH:		RELATION TO CHILD:	
Phone:	Home	Mobile			Work		
FAMILY CRN:		NO OF CHILDREN IN CARE (INCLUDING CHILD STATED ABOVE):					
WORK STATUS:	<input type="checkbox"/> NOT APPLICABLE		<input type="checkbox"/> WORK > THAN 15 HOURS PER WEEK		<input type="checkbox"/> LOOKING FOR WORK		
	<input type="checkbox"/> STUDYING/TRAINING		<input type="checkbox"/> 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:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emergency Contact:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excursion:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medication:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Authorised Contact 4

Name:		
Address:		
Phone	Mobile:	
	Home:	
	Work:	
Relationship to child:		
Able to Collect child:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emergency Contact:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excursion:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medication:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

HEALTH/MEDICAL DETAILS

DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS?:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, PROVIDE DETAILS:		
DOES YOUR CHILD REQUIRE REGULAR MEDICATION?:	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, PROVIDE DETAILS:	<input type="checkbox"/> Mild	<input type="checkbox"/> Severe <input type="checkbox"/> Anaphylaxis
IF ANAPHYLAXIS, DOCUMENT / MEDICATION SUPPLIED: <i>ACTION PLAN VALID FOR 1 YEAR FROM ISSUE</i>	<input type="checkbox"/> Anaphylaxis Action Plan Expiry Date:	<input type="checkbox"/> EPI Pen Expiry Date: <input type="checkbox"/> Other Medication Name: Expiry Date:
PLEASE PROVIDE ALLERGY MANAGEMENT PLAN RELATING TO YOUR CHILD.		

DOES YOUR CHILD SUFFER FROM ASTHMA?:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, PROVIDE DETAILS:	<input type="checkbox"/> Mild	<input type="checkbox"/> Severe
ASTHMA DOCUMENT / MEDICATION SUPPLIED: <i>ACTION PLAN VALID FOR 1 YEAR FROM ISSUE</i>	<input type="checkbox"/> Asthma Action Plan Expiry Date:	<input type="checkbox"/> Ventolin (ABCC) Expiry Date: <input type="checkbox"/> Ventolin College has given permission for child to carry and self-medicate.
PLEASE PROVIDE Asthma MANAGEMENT PLAN RELATING TO YOUR CHILD.		

IMMUNIZATION INFORMATION

IS YOUR CHILD'S IMMUNIZATION STATUS UP TO DATE?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23vPPV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DTPa	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hep A	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Hep B	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hib	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Influenza	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MMR	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MenCCV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
OPV/IPV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rotavirus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
VZV	<input type="checkbox"/> Yes	<input type="checkbox"/> No

DOES YOUR CHILD HAVE ANY SPECIFIC DIETARY REQUIREMENTS?:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DOES YOUR CHILD HAVE ANY FOOD INTOLERANCES?:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, PROVIDE DETAILS:		
IF YES, IS THE INTOLERANCE/ALLERGY LIFE THREATENING?:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
FOOD INTOLERANCE/ALLERGY MANAGEMENT PLANS SUPPLIED: MANAGEMENT PLAN VALID FOR 1 YEAR FROM ISSUE	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, PROVIDE DETAILS:		
DOES YOUR CHILD HAVE ANY DISLIKES, FEARS OR PHOBIAS?:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, PROVIDE DETAILS:		
IS YOUR CHILD OF ABORIGINAL OR TORRES STRAIT ISLANDER DESCENT?:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IS YOUR CHILD FROM A NON-ENGLISH SPEAKING BACKGROUND?:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, NATIONALITY:		
WOULD YOU LIKE INFORMATION FROM GOVERNMENT REGULATORS OR ADDITIONAL ABCC INFORMATION?:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF POSSIBLE, DO YOU REQUIRE A LANGUAGE OTHER THAN ENGLISH?:	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.

<i>PERMANENT DAYS:</i>		<i>BEFORE SCHOOL CARE</i>				
<i>WEEK 1</i>	<i>START DATE:</i>	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> Fri
<i>WEEK 2</i>	<i>START DATE:</i>	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> Fri

<i>PERMANENT DAYS:</i>		<i>AFTER SCHOOL CARE</i>				
<i>WEEK 1</i>	<i>START DATE:</i>	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> Fri
<i>WEEK 2</i>	<i>START DATE:</i>	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> 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)

- | | |
|--------------------------|---|
| <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | I authorize ABCC staff to liaise with other health/medical professionals in relation to the care of my child if required. |
| <input type="checkbox"/> | I agree to keep my child from attending the program should he/she be experiencing any illness or contagious disease. |
| <input type="checkbox"/> | I give permission for ABCC staff to assist my child to apply a SPF30+ sunscreen prior to outdoor activities OR BELOW |
| <input type="checkbox"/> | I will supply my own sunscreen for my child to apply a SPF 30+ sunscreen prior to outdoor activities |
| <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | I agree to receive promotional material, programs, newsletters and/or account statements via email. |
| <input type="checkbox"/> | 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:

<i>PLAYGROUNDS</i>	<i>OVAL</i>	<i>TENNIS COURTS</i>
<i>UNDER COVERED AREA</i>	<i>PRIMARY ABCC ROOMS</i>	<i>COLLEGE CHAPEL</i>

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 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
06/02/18			
20/02/18			
06/03/18			
20/03/18			
03/04/18			

Term 2

Date	Amount	Receipt	Processed by
01/05/18			
15/05/18			
29/05/18			
12/06/18			
26/06/18			

Term 3

Date	Amount	Receipt	Processed by
31/07/18			
14/08/18			
28/08/18			
11/09/18			
25/09/18			

Term 4

Date	Amount	Receipt	Processed by
23/10/18			
06/11/18			
20/11/18			
04/12/18*			

- To Finalise Term Payments for 2018

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
27/03/18			
03/04/18			
10/04/18			

Term 2

Date	Amount	Receipt	Processed by
19/06/18			
26/06/18			
03/07/18			
10/07/18			

Term 3

Date	Amount	Receipt	Processed by
18/09/18			
25/09/18			
01/10/18			

Term 4

Date	Amount	Receipt	Processed by
27/11/18			
4/12/18			
11/12/18			
18/12/18			
06/01/19			
13/01/19			