

Casual enrolment:
 Permanent enrolment:

Novita - Outside School Hours Care : TeenZone

171 Days Road
 Regency Park
 8243 8282

Enrolment Form: Part 1

CHILD

Family Name:
 First name: Other:
 Known as: Gender: F / M
 Date of birth: / / CRN:
 Address. No. / Street:
 Town/Suburb: Postcode:

PARENTING PLANS / ORDERS relating to this child

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ENROLLING PARENT/GUARDIAN & BILLING DETAILS

Name:
 Date of birth: / / CRN:
 Relationship to child: Contact Priority:
 Address: (h)
 (w)
 Phone: (h) (w) (m)
 Email:

EMERGENCY CONTACTS

Name: Contact Priority:
 Address: Relationship to child:
 Phone: (h) (w) (m)
 Name: Contact Priority:
 Address: Relationship to child:
 Phone: (h) (w) (m)

N.B. It is very important that you tell these people you have nominated them. In nominating them you give them the authority to act on the child's behalf if neither parent can be located, to pick up the child in an emergency and care for the child until s/he can be returned home.

CARE ELSEWHERE

I am claiming Childcare Benefit at other Approved Child Care Service/s (which includes LDC, OSHC, FDC, IHC, OCC) for this number of children:

OTHER PARENT/GUARDIAN (if applicable) Relationship to child:

Name: Contact Priority:
 Address: (h)
 (w)
 Phone: (h) (w) (m)

COLLECTION AUTHORITIES

Name: Relationship to child:
 Phone: (h) (w) (m)
 Name: Relationship to child:
 Phone: (h) (w) (m)

N.B. The people nominated here have been given approval only to collect the child and should NOT be contacted in case of an emergency.

Enrolment Form: Part 2

CHILD'S NAME:

MEDICAL AND HEALTH INFORMATION

Has the child received all immunisations appropriate for her/his age ?

Yes / No

If No, please give details:

I accept full responsibility if my child is not immunised.

Parent / Guardian signature:

Has the child any conditions / medications that may be effected by OSHC activities ?

If Yes, please give specifics and any related medication:

Has the child any additional / special needs ?

If Yes, please give specifics and any related medication (eg. Asthma - Ventalin):

Does the child usually require special aids (eg. glasses, hearing aid etc.) ?

If Yes, please give details:

Has the child any special dietary needs not related to allergies?

If Yes, please give specifics:

Has the child suffered any illness that may re-occur (e.g. chronic ear infection) ?

If Yes, please give details:

Has the child had any kind of allergic reactions ?

| | | | |
|--------|-------|------------------------|-------|
| Foods: | _____ | Reaction / Medication: | _____ |
| | _____ | | _____ |
| | _____ | | _____ |
| | _____ | | _____ |

Penicillin: _____ Reaction / Medication: _____

Others: _____ Reaction / Medication: _____

Is there any other medical information we might need to know ?

Note: Please supply the service with required medications in original containers with child's name clearly marked. Please complete a permission to administer medication form together with any medication records where necessary.

Usual Medical attendant

Doctor's name: _____ Phone No: _____

Clinic Name: _____

Address: _____

Usual Dental attendant

Dentist's name: _____ Phone No: _____

Clinic Name: _____

Address: _____

Medical Benefits cover with:

Ambulance cover with:

Medicare number:

Health Care Card number:

