

# **LINDEN PARK SCHOOL COUNCIL OSHC ENROLMENT FORM 2012**

14 Hay Road, Linden Park, SA, 5065 Ph: 8379 4610 Fax: 8379 2571 Mob: 0434 609 791

**FAMILY NAME (SURNAME)**.....

CHILD FIRST/GIVEN NAME..... BIRTH DATE..... CRN.....

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CHILD FIRST/GIVEN NAME..... BIRTH DATE..... CRN.....

CHILD FIRST/GIVEN NAME..... BIRTH DATE..... CRN.....

ADDRESS.....

PHONE NO..... LANGUAGE/S SPOKEN AT HOME. ....

EMAIL: .....

Please indicate whether you would like your account automatically e-mailed weekly (preferred method)

**Yes/No**

## **ENROLLING PARENT/GUARDIAN & BILLING DETAILS**

NAME: .....

DATE OF BIRTH: ..... CRN: .....

RELATIONSHIP TO CHILD: ..... CONTACT PRIORITY: .....

ADDRESS.....

PHONE: HOME: ..... WORK: ..... MOBILE: .....

**WORK PLACE:** .....

## **OTHER PARENT/GUARDIAN**

NAME: .....

RELATIONSHIP TO CHILD: ..... CONTACT PRIORITY: .....

ADDRESS.....

PHONE: HOME: ..... WORK: ..... MOBILE: .....

**WORK PLACE:** .....

## **PLEASE LIST ALL OTHER PERSONS WITH AUTHORITY TO COLLECT CHILD FROM CENTRE & PHONE NOS.**

NAME..... Relationship to Child:.....

PHONE: HOME:..... WORK: ..... MOBILE: .....

NAME..... Relationship to Child:.....

PHONE: HOME:..... WORK: ..... MOBILE: .....

NAME..... Relationship to Child:.....

PHONE: HOME:..... WORK: ..... MOBILE: .....

**CUSTODY (to be completed if custody is an issue for the family).**

If parents are separated/divorced;  
Does the child have contact with the other parent?.....  
Is anyone legally denied access to the child?..... Any other relevant information

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.....  
.....

Please list the days and times of custody for each parent, and who is responsible for payment of fees on which nights or mornings.

..... (name of parent) ..... (days or weeks responsible) ..... (times & days responsible for OSHC payments)	..... (name of parent) ..... (days or weeks responsible) ..... (times & days responsible for OSHC payments)
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**EMERGENCY CONTACT PERSON (if parents are unable to be contacted)**

NAME: .....  
RELATIONSHIP TO CHILD.....  
ADDRESS.....  
PHONE: HOME:..... WORK: ..... MOBILE: .....

**DOCTOR'S NAME:** .....  
ADDRESS: .....  
PHONE NO: .....

**MEDICAL ATTENTION IN CASE OF EMERGENCY**

In case of accident or emergency, every effort will be made to contact parents prior to seeking treatment. In the event my child receiving injuries requiring urgent medical attention, I authorise the seeking of medical attention and agree to pay all costs incurred on behalf of my child.

**PARENT/GUARDIAN'S SIGNATURE**.....

I AM AWARE OF ARRIVAL AND PICK-UP PROCEDURES FOR MY CHILD AT THIS CENTRE. I HAVE READ AND UNDERSTAND THE LINDEN PARK SCHOOL COUNCIL OSHC POLICY, AND ACCEPT THE CONDITIONS OF SAME. I ALSO UNDERSTAND THAT CHILD CARE ACCOUNTS ARE TO BE PAID REGULARLY AND AT LEAST FORTNIGHTLY. SHOULD THE SERVICE HAVE TO PUT THE ACCOUNT INTO THE HANDS OF A DEBT COLLECTION AGENCY OR SOLICITOR BECAUSE OF NON-PAYMENT OF FEES, I WILL BE RESPONSIBLE FOR ANY FEES INCURRED.

**PARENT/GUARDIAN'S SIGNATURE**.....

**PARENT/GUARDIAN'S SIGNATURE**.....

**DATE OF SIGNING**.....