2026 - Para Vista OSHC Enrolment Form - **NEW CHILD**

CONFIDENTIAL: RESTRICTED ACCESS

PARA VISTA OSHC & VACATION CARE

PARA VISTA PRIMARY SCHOOL

351 Montague Road, Para Vista SA 5093 | PH: 0408 196 535

CHILD DETAILS

First Name: _____ Family Name: _____

Preferred name if different from above: _____

Gender: Male / Female / Other

Date of Birth: _____ / _____ / _____

CRN (Centrelink reference number—Different to parents): ☐☐☐☐☐☐☐☐☐☐

Address: _____

Suburb/town: _____ Post Code: _____

Attending: Para Vista Primary School ☐ Para Vista Pre-School ☐

ACCOUNT HOLDER/BILLING DETAILS

First Name: _____Family Name: _____

Date of Birth: _____ / _____ / _____ Relationship to Child: _____

Priority contact in an emergency? First/Second

CRN (Centrelink reference number) ☐☐☐☐☐☐☐☐☐☐

Email address: _____

Phone: (H) _____ (W)_____ (M)_____

Address: _____

Suburb/town: _____ Post Code: _____

OTHER PARENT/GUARDIAN (if applicable) Relationship: _____

First Name: _____Family Name: _____

Phone: (H) _____ (W)_____ (M)_____

Email address: _____

Priority contact in an emergency? First/Second/None

OTHER CHILDREN IN CARE

I am claiming Child Care Benefit at other approved Child Care Services (including LDC, OSHC, FDC, IHC, OCC) for this amount of children: ☐

PARENTING PLANS/ORDERS (relating to this child):

_____

_____

OTHER PRIORITY CONTACTS AND COLLECTION AUTHORITIES

Complete in the order that you would like contacted in an emergency if you and the other parent/guardian listed cannot be reached.

***Must be adults over the age of 18.**

Priority 1

Full Name: _____ Relationship: _____

Phone: (H) _____ (W)_____ (M)_____

Priority 2

Full Name: _____ Relationship: _____

Phone: (H) _____ (W)_____ (M)_____

Priority 3

Full Name: _____ Relationship: _____

Phone: (H) _____ (W)_____ (M)_____

List any other collection authorities that are not priority contacts below.

Full Name: _____ Relationship: _____

Phone: (H) _____ (W)_____ (M)_____

Full Name: _____ Relationship: _____

Phone: (H) _____ (W)_____ (M)_____

Full Name: _____ Relationship: _____

Phone: (H) _____ (W)_____ (M)_____

MEDICAL HEALTH INFORMATION

Has your child received all immunizations appropriate for their age? **Yes / No**
If no, please give details below:

_____

_____

I accept full responsibility if my child is not immunized.

Parent/guardian signature: _____

Does your child have any conditions that may be effected by OSHC activities? **Yes / No**
If yes, please give details and management strategies: below (e.g. Asthma - Ventolin)

_____

_____

Does your child have any additional / special needs? **Yes / No**
If yes, please give details below:
***All relevant documentation will need to be provided to the service prior to care to ensure adequate support can be provided.**

_____

_____

Is your child **fully** toilet trained? **Yes / No**

***Children must be fully toilet trained to attend OSHC as we do not have the necessary nappy changing facilities required to adequately meet support needs.**

Does your child usually require any special aids? **Yes / No**
If yes, please give details below: (e.g. hearing aid, glasses)

_____

_____

Does your child have any special dietary needs not related to allergies? **Yes / No**
If yes, please give details below: (E.g. vegetarian, vegan)

_____

_____

Has your child suffered any illness that may re-occur? **Yes / No**
If yes, please give details below:

_____

_____

Does your child have any kind of allergic reactions? **Yes / No**
If yes, please give details: (include what they are allergic to, the reaction and medication that needs to be used)

Allergy	Reaction	Medication

Is there any other medical information we might need to know? **Yes / No**
If yes, please give details below:

_____

_____

NOTE: All medication must be supplied in original packaging with a chemist label stating the child's name and dosage. The service must also be provided with a copy of the child's current medical action plan from a doctor before the child can attend care at the service.

I give permission for a staff member with first aid training to administer the above medication provided to the service for the prescribed child.

Please sign: _____

Doctor's Name: _____ Phone: _____

Clinic Name: _____

Address: _____

Dentist's Name: _____ Phone: _____

Clinic Name: _____

Address: _____

Medical Benefits cover with: _____

Ambulance cover with: _____

Medicare Number: _____

Health Care Card Number: _____

About Your Family

Who would you say make up your immediate family?
(E.g. Mum, Dad, siblings, Grandma, Grandpa)

What is your cultural background?
We have a world map sharing all of our children's family backgrounds so we'd love to have your child included too.

What cultural or religious holidays do you celebrate at home?

Does your family speak any languages other then English? Yes / No
If yes, which languages?

As part of our OSHC community we encourage families to share their background with the OSHC service. **Please list any interests or expertise you would be willing to share with the service (E.g. cultural, occupational, hobbies)**

Are you of Aboriginal or Torres Strait Islander origin ? Yes / No
If yes, please elaborate below:

About your child

My child's favourite things to do are….

My child's favourite foods are….

Is there any other information about your child or family we should know to better cater to your needs?

IS THERE ANYTHING ELSE WE NEED TO KNOW?

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BOOKINGS

For **permanent bookings** indicate with an **X** the sessions that you would like your child to attend care. Please ensure you list a start date.

PLEASE NOTE:
Vacation Care and Pupil Free Day bookings need to be made separately.
***Priority of access will be given to school age children.**

PERMANENT: ☐ OR **CASUAL:** ☐

WEEKLY: ☐ OR **FORTNIGHTLY:** ☐

Please complete for **weekly** bookings that will be the same each week:

START DATE: _____

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Before School					
After School					

OR

Please complete for **fortnightly** bookings that will alternate each week:

START DATE: _____

FIRST WEEK					
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Before School					
After School					

SECOND WEEK					
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Before School					
After School					

CONSENTS

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Please initial the following to indicate consent and that you have read and understood the terms and conditions.

I give permission for staff to observe and record interactions and activities my child takes part in for programming and developmental purposes. **INT…….**

I give permission for my child to be photographed and for their image and name to be published in circumstances OSHC leadership deem appropriate. E.g. OSHC room displays and the school newsletter. **INT…….**

I give permission for my child to watch movies and play games rated 'PG' under the supervision and guidance of staff. **INT…….**

I give permission for staff with first aid training to administer first aid to my child if the need arises. I understand that if at any time the staff consider that my child requires emergency medical assistance they will call for an ambulance and I will be liable for the expenses incurred. **INT…….**

I give permission for OSHC provided sunscreen to be applied should my child not have their own sunscreen. I also give permission for staff to assist with application if required. **INT…….**

I am aware that if I do not provide my child with an appropriate hat for outside activities when required they will not be able to participate in those activities. I understand that if my child does not have an appropriate hat they may be supplied with one if necessary to ensure safety which will then be charged to my account. **INT…….**

I understand that my child must wear enclosed shoes to ensure safety at all times. Thongs or slip on shoes are not permitted. Children must also wear appropriate clothing which covers shoulders. The service reserves the right to send children home if they are not dressed safely or appropriately. **INT…….**

I am aware that toys, valuables and electronic devices including mobile phones and smart watches are not to be brought to the service. If found, they will be confiscated until the child is collected. The service will not be responsible for any lost or damaged items. **INT…….**

I understand that cancellation of care during the school term must occur with at least 48 hours notice in order not to be charged. A half fee will apply if cancellation occurs between 24 hours and 48 hours prior or if my child is sick and a medical certificate is supplied. I understand that if I do not inform the service of my child's absence prior to care additional fees will apply. **INT…….**

I have made the service aware of all necessary enrolment details and my child's medical information. If my child requires medication I have provided medical action plans for the administration of the medication. I have provided all required medication in original packaging with a chemist label stating the child's name, dosage and administration instructions. **INT…….**

AGREEMENT

I agree to pay all fees within one week of care provided. Overdue accounts will be sent for debt collection and any fees incurred will be charged in addition to my account. Any outstanding accounts must be paid before children can attend care in 2026.

I accept the services policies and procedures and will ensure my child and I follow them.

I understand that Vacation Care and Pupil Free Days are booked separately from during the school term and I am responsible to book my child in for care if required.

Parent/guardian signature: **Date:**

Director signature (if accepted): **Date:**

ALL-ABOUT-ME ROBOT

MY NAME IS:

_____

Write your name here.

Draw a picture of yourself here.

I AM SPECIAL BECAUSE:

FUN FACTS ABOUT ME

- MY TEACHER IS: _____
- MY BIRTHDAY IS: _____
- THE MEMBERS OF MY FAMILY ARE: _____
  _____
  _____
- WHEN I GROW UP, I WANT TO BE: _____
  _____

I HELP OTHERS BY:

FAVORITE COLOR:

SOMETHING I LIKE TO DO AT SCHOOL IS:

SOMETHING I LIKE TO DO AT HOME IS:

FAVORITE FOOD:

FAVORITE ANIMAL:

FAVORITE BOOK: