PRESHIL
THE MARGARET LYTTLE MEMORIAL SCHOOL

**AFTERCARE REGISTRATION FORM 2015**

**Child's Personal Details –**

Family Name: ……..….. Date of Birth: …….. Sex: M ☐ F ☐ (please tick)

Given Names: ……Usually called:… ……..Grade:……...

Home Address: ……

Phone: Home:……..…… Mobile: …….. Work: ……..……

Address during term (if different to Home Address): ……..…….....

Language(s)spoken in the home: ……

Is the child of Aboriginal or Torres Strait Islander origin? (Yes/No) ……..

## CHILD'S MEDICAL DETAILS:

Name of family Doctor: …….....

Doctor/Clinic Address:…….....

Telephone Number: ……..

Does your child have a Medical Condition or Major Illness: (give details)

……..

Please TICK if your child suffers any of the following:

☐ Fits of any type ☐ Heart condition
☐ Dizzy spells ☐ Blackouts ☐ Migraine
☐ Travel sickness ☐ Epilepsy ☐ Other ……

Does your child suffer from Asthma? (Yes/No) ……... **If YES please attach the treatment plan given by your doctor.**

Does your child have known allergies? (Yes/No) ……. **If YES then please TICK the type of allergy:**

☐ Penicillin or other drugs ☐ Any foods ☐ Any plants ☐ Other

Please provide details:

……..……..……..

……..

Is your child anaphylactic? (Yes/No) …….. **If YES, please attach the treatment plan given by your doctor.**

Does your child have any disabilities? (Yes/No) …… **If YES then please TICK the type of impairment/s**:

☐ Hearing ☐ Visual ☐ Speech ☐ Physical

Medications: Please list any regular medications your child requires –dosages and medication times:

…….....

Medicare Number …… Private Health Fund (Name & No.):……...……

Is the student covered by the Ambulance Fund for emergency transport by Ambulance? (Yes/No) ……

Your Ambulance Number……

## CHILD'S IMMUNISATION RECORD

Has your child been immunised against the following? (please TICK Yes or No)

| | | |
|---|---|---|
| MMR (Measles, Mumps, Rubella) | ☐ Yes | ☐ No |
| Triple Antigen (Diphtheria/Tetanus/Pertussis) | ☐ Yes | ☐ No |
| OPV (Oral Polio Vaccine – Sabin) | ☐ Yes | ☐ No |
| Hepatitis B | ☐ Yes | ☐ No |
| Hib (PedvaxHIB/HibTITER) | ☐ Yes | ☐ No |
| BCG | ☐ Yes | ☐ No |
| Meningococcal | ☐ Yes | ☐ No |
| Chicken Pox (Varicella) | ☐ Yes | ☐ No |
| Gardasil (Cervical Cancer Vaccine – HPV) | ☐ Yes | ☐ No |

Other……..

Have you provided an up-to-date copy of the immunisation record ? ☐ Yes ☐ No
If no, provide details by:

- Attaching a copy of the Immunisation Record from the Child Health Record Book OR
- Attaching a copy of the Immunisation record print-out from the local government.

## BOOKING DETAILS

I would like to book:

☐ On a Casual Basis **OR**

☐ On a Permanent Basis: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday
☐ Weekly ☐ Fortnightly (Please tick appropriate boxes)

## CONSENT TO MEDICAL ATTENTION

**In the event of illness or injury to my child whilst attending the After School Care program I authorise the Coordinator the Principal or person in charge of my child, where the Coordinator, Principal or person in charge is unable to contact me, or it is otherwise impracticable to contact me to:**

- Consent to my child receiving such medical or surgical attention as may be deemed necessary by a medical practitioner;
- Administer such first aid as the Principal or staff member may judge to be reasonably necessary;
- Call an Ambulance if deemed necessary by a staff member.

**Signature(s) of Parents/Guardians** ……..……... ……..
Date / / Date / /

## CHILD CARE BENEFIT DETAILS

Do you currently collect the Child Care Benefit? (Yes/No): ……..

Family CRN number…….……Child's CRN number……..

Do you intend to apply for the Child Care Benefit? (Yes/No): ……...

(To apply for the Child Care Benefit please contact your Family Assistance Office located at your Medicare office, go on line to **www.familyassist.gov.au** or ring 136 150.)

## Parents/Guardian Information

Please cross out what is not applicable

| Mother/Female Guardian | Father/Male Guardian |
|---|---|
| Title …. . Family Name……..… | Title …. . Family Name…….……..…… |
| First Name …….. | First Name ……..……..…. |
| Date of Birth…….. | Date of Birth:…… |
| **Address** | **Address** |
| Number & Street ……..…….. | Number & Street ……...…….…… |
| Suburb ……..…..…. P/C…… | Suburb ……. P/C…….…… |
| Ph: (H) ……..…… (W)……... | Ph: (H) ……..…. (W)……..……... |
| Ph: (M) ……..…….. | Ph: (M) ……..……..…….. |
| Email: ……..…… | Email: ……...…… |
| Occupation …… | Occupation ……..……..... |
| Employer's name: ……..…… | . Employer's name: ……..…….. |
| Employer's address: …… | Employer's address: …… |
| …….. | ……...…… |

If time is spent between 2 residential addresses, please circle appropriate days at each

| M T W Th F Sa Su | M T W Th F Sa Su |
|---|---|
| | |

## EMERGENCY CONTACT INFORMATION INCLUDING OTHERS THAT MAY BE ABLE TO COLLECT YOUR CHILD/REN

Please be assured we always try to contact parents first.

| **First authorised and/or Emergency Contact to collect child/ren** | **Second authorised and/or Emergency Contact to collect child/ren** |
|---|---|
| Name: ……..……..…… | Name: …… |
| Relationship to student: …… | Relationship to student: …… |
| Ph: (H) ……..……(W)……..…..…….. | Ph: (H) ……..……(W)……...…….. |
| (M) …….. | (M) …….. |

**The School MUST be notified of any changes to details contained in this Registration Form.**

## COURT ORDERS RELATING TO THE CHILD

Are there any court orders relating to the powers and responsibilities of the parents in relation to the child or access to the child?

No ☐ (Go to the next section)

Yes ☐ (**Please complete the following**)

Please attach certified copies of current court orders. If these orders:

(a) change the powers of a parent/guardian to:

- authorise the taking of the child outside the school grounds by a staff member;
- consent to the medical treatment of the child;
- request or permit the administration of medication to the child;
- collect the child, AND/OR

(b) give these powers to someone else;

please describe these changes and provide the contact details of any person given these powers:

……

……

## PRIVACY

The School is bound by the National Privacy Principles contained in the Commonwealth Privacy Act. In relation to health records, the School is also bound by the Victorian Privacy Principles which are contained in the Health Records Act 2001.

The School has in place steps to protect the personal information the School holds from misuse, loss, unauthorised access, modification or disclosure by use of various methods including locked storage of paper records and pass-worded access rights to computerised record

**Would you like to provide any additional information?**

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……

……

**I state that all the above information on this Registration Form is true and correct**

**…….(Signature) Date:…….**

**Print name:……**