



The Summit After School Care and Vacation Care

ENROLMENT DETAILS

Child's Room: - *After School Care/Vacation Care*

Child's day's:- *Mon/Tue/Wed/Thu/Fri*

Name of School attended: _____

Child's start date: _____

Family C.C.B %: _____ No. of Children in Care _____

Administration Fee \$ _____ 50.00

Refundable Bond(Equivalent to 2 Weeks ASC)\$ _____

Two Weeks Fee in advance (ASC only)\$ _____

TOTAL AMOUNT TO BE PAID ON ENROLMENT \$.....

(Your child's place will not be secured until advanced Fees have been Paid)

Estimated Normal Weekly Fee \$ _____

Payment Options:

Cash
Eftpos
Cheque

Credit Card
Netbank
Direct Debit(from Credit card)

Mailing Address

1-3 Cathie Road
Port Macquarie
N.S.W 2444
Phone: 65825400
Fax: 65825676

Bank Account Details

National Australia Bank
Port Macquarie
B.S.B- 082 798
Account number – 797 411 658

**After School Care Service number: .. 407 221 206V
Vacation Care Service Number 407 223 684K
Family Assistant Office: 136150**

**PLEASE PROVIDE IMMUNISATION DETAILS
AND BIRTH CERTIFICATE UPON ENROLMENT**

The Summit Before & After School Care

1-3 Cathie Road PORT MACQUARIE NSW 2444 Tel: 02 65825400

Enrolment Form

Child's Given Name: Child's Family Name:
Other Names the Child is known by:
Other Names the Child has been known by:
M / F: DOB: Address:
Place of Birth:
Home Phone: Bill Fees To:
Legal Guardian: Religion:
Indigenous Status:
Primary Language: Cultural Background:
Special Needs (Y/N): Disability (Y/N):
Is there anyone who is prohibited from having contact with or collecting the child?

Days Req'd Mon Tues Wed Thur Fri Hours of Care Req'd Start Date Req'd

Information required to claim CCB:

CCB Hours Nominated (Y/N): If Yes - Hours to be used in this Centre:

Child's CRN:

Parent/Guardian/Claimant Name:

Parent/Guardian/Claimant Date of Birth: CRN:

Important: Please make sure that the Parent/Guardian/Claimant Date of Birth, and the Parent/Guardian/Claimant CRN are for the person claiming CCB.

Mother's Given Name: Mother's Family Name:

Other Names the Mother is known by:

Other Names the Mother has been known by:

Address:

Home Phone: Mobile Phone:

Email Address:

Work Details Mother: Employer: Suburb:

Phone (W): Hours: Occupation:

Father's Given Name: Father's Family Name:

Other Names the Father is known by:

Other Names the Father has been known by:

Address:

Home Phone: Mobile Phone:

Email Address:

Work Details Father: Employer: Suburb:

Phone (W): Hours: Occupation:

Medical Details:

Does your Child take regular medication or have any disabilities, food sensitivities or allergies we should know about? Yes/No

If Yes give details:

Is there any other information you wish us to know about your child?

Has your Child had any of the following? Y/N Measles German Measles Ear Infection Hepatitis
Mumps Chicken Pox Throat Infection

Medicare No: Private Health Particulars:

Emergency Details:

Doctor's Name: Phone No: Contact Doctor Y/N

Address:

Dentist's Name: Phone No: Contact Dentist Y/N

Religious Requirements in case of Accident:

Using the boxes below, list at least 2 people authorised to collect the child and at least 2 people that we may call if we cannot find you in an emergency. These may be the same people for both situations.

Person's Name	Relationship to Child	Phone (H)	Phone (W)	Phone (Mobile)	Emerg. Release Y/N	Daily Pick Up Y/N

Home Address:

Work Address:

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Home Address:

Work Address:

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Home Address:

Work Address:

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Home Address:

Work Address:

In the Event of an emergency, illness or accident concerning my child, I consent to the service seeking on my behalf urgent medical, dental, hospital and ambulance services for my child and I consent to the carrying out of appropriate medical, dental or hospital treatment in the event that such action appears to be necessary because my child has been injured, or is ill, at the premises. I accept any liability for medical, dental, hospital and ambulance that may be incurred.

I understand that the authorised supervisor of the service will, as soon as practically possible, notify me or other persons so authorised by me of the accident or illness and the treatment or services arranged for my child.

Parent Signature Date

Please supply evidence of immunisation - either your Blue Book or a letter from your doctor.

Supplementary Enrolment Questions

1. I agree to my child's photograph being used for digital documentation and publicity for the centre.

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2. I will apply sunscreen before arrival & give permission for staff to re-apply sunscreen to my child.

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3. I hereby acknowledge that I have received the Information Sheet and agree to abide by its policies.

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4. Is your child Immunized? I agree to supply proof of my child's immunisation.

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5. Is there any other information you wish us to know about your child? e.g routines/allergies etc.

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6. I agree to pay my fees two weeks in advance (ASC only)

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7. If headlice is suspected in the centre, I give permission for my child's hair to be checked.

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8. In an emergency eg High temp,I give permission for my child to be given panadol if I'm uncontactable.

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Parent Signature:.....Date:.....

