



St Martins Lutheran College
Grow in Christ | Growing the Future

Application for Enrolment

St Martins Out of School Hours Care

Known as- **SMOSHC**

3 St Martins Drive, Mount Gambier, SA 5290

SMOSHC Mobile: 0418 815 101

Email: oshc@stmartins.sa.edu.au

FOR OFFICE USE ONLY

Family Name:

.....

Student Name/s:

.....

.....

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To begin:

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STUDENT INFORMATION	CHILD 1	CHILD 2	CHILD 3	CHILD 4
Surname:				
Given Name/s:				
Preferred Name:				
Gender:	Male / Female	Male / Female	Male / Female	Male / Female
Date of Birth:				
Current Year Level:				
To Start:	ASAP/ Mid-year intake (Reception)	ASAP/ Mid-year intake (Reception)	ASAP/ Mid-year intake (Reception)	ASAP/ Mid-year intake (Reception)
Language Spoken at Home:				
Aboriginal:	Yes / No	Yes / No	Yes / No	Yes / No
Torres Strait Islander:	Yes / No	Yes / No	Yes / No	Yes / No
Student lives with:	Both Parents / Mother / Father / Caregiver	Both Parents / Mother / Father / Caregiver	Both Parents / Mother / Father / Caregiver	Both Parents / Mother / Father / Caregiver

PARENT / GUARDIAN INFORMATION
Family and address details where student resides

Title:	Parent / Carer 1 Mr Mrs Ms Miss	Parent / Carer 2 Mr Mrs Ms Miss
Full Name:		
Relationship to Student:		
Mobile Number:		
Alternative Phone:		
Email:		
Home Address:		
Aboriginal:	Yes / No Torres Strait Islander: Yes / No	Yes / No Torres Strait Islander: Yes / No
Is English your first language?		
If no, first spoken language:		

EMERGENCY CONTACTS / AUTHORITY TO COLLECT (Other than Parent or Guardian)

In nominating them you give them authority to act on the child/ren's behalf if neither Parent/Guardian can be located.
THE CHILD/REN WILL ONLY BE RELEASED TO A NOMINATED PERSON.
 They must be over 18 years old at the time of nomination and be available to pick up or child during the hours of care.
Authorisations can be added or removed at any time with permission.
Only two (2) Emergency Contacts required.

Title:	Emergency Contact 1 Mr Mrs Ms Miss	Emergency Contact 2 Mr Mrs Ms Miss
Full Name:		
Relationship to Student:		
Mobile Number:		
Alternative Phone:		
Home Address:		
Is English your first language?	Yes / No	Yes / No
If no, first spoken language:		
This Person has permission on my behalf:	<input type="checkbox"/> Collection <input type="checkbox"/> Excursion <input type="checkbox"/> Medical	<input type="checkbox"/> Collection <input type="checkbox"/> Excursion <input type="checkbox"/> Medical
Title:	Optional: Emergency Contact 3 Mr Mrs Ms Miss	Optional: Emergency Contact 4 Mr Mrs Ms Miss
Full Name:		
Relationship to Student:		
Mobile Number:		
Alternative Phone:		
Home Address:		
Is English your first language?	Yes / No	Yes / No
If no, first spoken language:		
This Person has permission on my behalf:	<input type="checkbox"/> Collection <input type="checkbox"/> Excursion <input type="checkbox"/> Medical	<input type="checkbox"/> Collection <input type="checkbox"/> Excursion <input type="checkbox"/> Medical

Collection: This gives the person permission to pick up children. They must be over 18 years old and be available to pick up your child during the hours of care and be within a reasonable distance from the service. Please note we require at least two emergency pick up contacts.

Excursion: This gives the person authority to permit an educator or allow another adult to take your child outside the education and care premises.

Medical: This gives the person authority to consent to medical treatment for your children from a medical practitioner, hospital and/or ambulance service

MEDICAL AND SPECIAL NEEDS INFORMATION

	CHILD 1	CHILD 2	CHILD 3	CHILD 4
Are there any details, needs and considerations about your child/ren/family that the SMOSHC service should be aware of?	Yes / No	Yes / No	Yes / No	Yes / No
Does the student have any known or suspected special needs or health issues?	<input type="radio"/> Seizures/Epilepsy <input type="radio"/> ASD/ADHD <input type="radio"/> Asthma <input type="radio"/> Allergies (food) <input type="radio"/> Allergies (other) <input type="radio"/> Other.....	<input type="radio"/> Seizures/Epilepsy <input type="radio"/> ASD/ADHD <input type="radio"/> Asthma <input type="radio"/> Allergies (food) <input type="radio"/> Allergies (other) <input type="radio"/> Other.....	<input type="radio"/> Seizures/Epilepsy <input type="radio"/> ASD/ADHD <input type="radio"/> Asthma <input type="radio"/> Allergies (food) <input type="radio"/> Allergies (other) <input type="radio"/> Other.....	<input type="radio"/> Seizures/Epilepsy <input type="radio"/> ASD/ADHD <input type="radio"/> Asthma <input type="radio"/> Allergies (food) <input type="radio"/> Allergies (other) <input type="radio"/> Other.....

If you answered YES to any of the above please provide full details and documentation of those needs or health issues and any interventional support that the child may be currently receiving. Any health care needs we will require a **Medical Action Plan and Action Plan this must be in consultation with a doctor**. Please note that SMOSHC must be provided with its own set of clearly labelled medication. *Failure to disclose this information may impede our ability to cater to the student's needs or acceptance of enrolment or future bookings:*

CHILD 1:

What is the nature of the condition?.....

- I have submitted a Medical Management Plan in consultation with the SMOSHC Director or Assistant Director.
- Any Action Plan has been reviewed from a doctor within the last 12 months.

CHILD 2:

What is the nature of the condition?.....

- I have submitted a Medical Management Plan in consultation with the SMOSHC Director or Assistant Director.
- Any Action Plan has been reviewed from a doctor within the last 12 months.

CHILD 3:

What is the nature of the condition?.....

- I have submitted a Medical Management Plan in consultation with the SMOSHC Director or Assistant Director.
- Any Action Plan has been reviewed from a doctor within the last 12 months.

CHILD 4:

What is the nature of the condition?.....

- I have submitted a Medical Management Plan in consultation with the SMOSHC Director or Assistant Director.
- Any Action Plan has been reviewed from a doctor within the last 12 months

CONCENT TO MEDICAL ATTENTION PLEASE CIRCLE: Yes / No

In the event of illness or injury requiring urgent medical treatment I consent for medical and / or hospital attention to be sought. If Ambulance travel is required the cost is the responsibility of the student's parents/guardians. St Martins Lutheran College does not hold blanket Ambulance cover for students and staff. Parents / Guardians or emergency contacts will be contacted immediately in these events.

SIGNED..... NAME..... DATE.....

SMOSHC Enrolment Agreement

I give Permission for SMOSHC staff to administer medication to my child/ren when directed by the parent/caregiver.	Yes/ No
First aid: in the case of medical emergency, I give permission to staff to provide First Aid to my child/ren in the event of accident or illness.	Yes/ No
Family Handbook: I have received and read a copy of the Family Handbook and agree to be bound by the information and policies outlined. Digital copies are available on our website.	Yes/ No
I am aware of arrival and pick up process and fee structure for my child/ren utilising the SMOSHC service.	Yes/ No
I accept the policies and rules of St Martins Lutheran College will apply to SMOSHC. All Policies and Procedures for SMOSHC are available upon request or a digital copy is available on our website.	Yes/ No
I am aware that SMOSHC staff may exchange information relating to my child/ren with school staff and to the appropriate person(s) (e.g., in an emergency/ special need of my child/ren). I understand that this information will be handled confidentially.	Yes/ No
I agree that SMOSHC does not accept liability for damage or loss of any personal possessions of my child/ren and that insurance of my child/ren's personal possessions is my responsibility.	Yes/ No
I give permission for my child/ren to participate in supervised walks/visits to a local park/playground as part of the SMOSHC program. I understand it is my responsibility to advise SMOSHC staff if I do not want my child/ren to participate in a particular activity. SMOSHC will advise you separately of any details prior to any Student Free Days or Vacation Care excursions.	Yes/ No

Media Consent

I CONSENT for my child/ren to be in photos while at the SMOSHC service for their image/s to be used on the media documentation platforms for <u>personal and private</u> documenting of their "Learning Journey".	Yes/ No
I CONSENT for the image/s of my child/ren to appear in <u>other children's images</u> and shared in <u>their peers</u> personal and private documentation of their "Learning Journey".	Yes/ No
I CONSENT for my child/ren's name (first name only) to be used <u>in their peers' personal and private</u> documentation of their "Learning Journey".	Yes/ No
I CONSENT for my child/ren's <i>image</i> to be displayed at the <u>SMOSHC service</u> .	Yes/ No
I CONSENT for my child/ren's image to be used at the discretion of the SMOSHC Director or Assistant Director. This may be inclusive of <u>external media</u> for school and SMOSHC purposes, traditional media (newspaper, radio and television). Social media (college Facebook, Instagram) college website and newsletter. Last names will NOT be used by the SMOSHC Director, Assistant Director or SMOSHC staff in any documentation.	Yes/ No

Payment

I AGREE that all bookings are to be paid at the time of bookings via the QKR! App. Any and all late bookings manually booked with the SMOSHC Director or Assistant Director are to be paid in full on the day of booking through the QKR! App.

SIGNED.....NAME.....DATE.....

Custody

Custody of the child/ren. (To be completed if custody is an issue for the family) Is anyone legally denied to the child/ren? Please provide staff with copies of the Family Court orders and any relevant legal documents regarding family issues:

CHILD 1:

CHILD 2:

CHILD 3:

CHILD 4:

Disclaimer

I Hereby state that the above information supplied is current and all information that may affect my child/ren's care at St Martin's Out of School Hours Care has been included.

I understand that my responses to the above questions will be acted upon as I have directed and any alteration to this information made by me will need to be in writing.

SIGNED.....NAME.....DATE.....