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| **PARENTS/GUARDIANS INFORMATION** |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | **Full Name** | **Date of Birth** | | **Daytime Phone** | | **Mobile** | **CRN (Customer Reference Number with Centrelink)** | | **Mother** |  |  | |  | |  |  | | **Father** |  |  | |  | |  |  | | **Joint Carer** |  |  | |  | |  | | | **Home Address** |  | | |  | | **Home Phone** |  | | **Email** |  | | |  | |  | | | **Custody Details / Parenting orders or plans (of which to be aware)** | | |  | |  | | |   I give the following emergency contacts authorization to, either one, any or all of the following, if I cannot be contacted:   1. Collect child 2. Consent to medical treatment 3. Consent to seek treatment from registered medical practitioner/ hospital/ ambulance 4. Consent to seek transportation of the child by an ambulance service 5. Authorize an educator to take the child out of the centre on excursions  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Emergency Contacts** | | | | | |  | | **Full Name** | | **Address** | **Mobile/ Phone** | | **Consent Given to: (Please circle)** | **Mobile** | |  | |  |  | | **1 2 3 4 5** |  | |  | |  |  | | **1 2 3 4 5** |  | |  | |  |  | | **1 2 3 4 5** |  | |  | |  |  | | **1 2 3 4 5** |  | |  | |  |  | | **1 2 3 4 5** |  | | **Parent Name** |  | | **Signature** |  | |  | |

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| **Family Name:** | | | | **Address of the child:** | | | |
| **Child’s Name** | **Date of Birth** | | **M/F** | **Class** | | **CRN (Customer Reference Number with Centrelink)** | |
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| **Any special cultural, religious or dietary considerations or special needs** | |  | | | | | |
| **Cultural Background** | |  | | | **Language used in child’s home** | |  |

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| **Medical Information** | | | | | | |
| **I consent to commence First Aid or Medical Treatment (please circle)** | | | **Yes**  **No** | **Signature:** |  | |
| **Doctor’s Name** |  | | | **Clinic Name** |  | |
| **Address** |  | | | **Phone Number** |  | |
| **Child’s Medicare Number** |  | | |  |  | |
| **Specific Health Care Needs or Conditions** |  | | | **Details of any allergies** |  | |
| **Has your child been diagnosed as at risk of anaphylaxis?** |  | | | **Details of any dietary restrictions** |  | |
| **Details of any Medical Management Plan** |  | | | | | |
| **Health Record Sighted Y/N** |  | **Immunization Status Up-to-Date Y/N** | | | |  |

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| **Vacation Care Required** | |
| **Please circle** | **$60 per day** |

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| **Days** |
|  | **Monday**  **25.01.2016** | **Public Holiday**  **OSHC closed** | **Wednesday**  **27.01.2016** | **Thursday**  **28.01.2016** |  |

**Please be advised that you will incur a late fee of $5 per minute for any late pick up. Vacation Care closing time is 5:30pm during this holiday break.**

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| **Payment** |
| 1. Internet Banking: Name of the Account: St Mary’s Catholic Primary School   Name of Bank: NAB  BSB: 085 933  Account Number: 39 686 0268  Please note whether payment is to Vacation Care, BSC or ASC   1. EFTPOS / Credit Card (VISA or Mastercard) 2. Cheque 3. Cash 4. Please note that the days you select are the days for which you will automatically be charged. 5. Any expenses, costs or disbursements incurred by St Mary’s Catholic Primary School in recovering any outstanding monies, including debt collection agency fees and solicitors plus out of pocket expenses, shall be paid by the customer on demand.   **Please maintain your account at least one week in advance.** |

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| **Signature:**  **Print Name:**  **Date:** | **Signature:**  **Print Name:**  **Date:** |