

Holy Family COOSH



Holy Family Care Out Of School Hours (COOSH) Enrolment Form

In accordance with the Catholic Education Office Enrolment Policy and Regulations

Family Name

Child 1

*If you have more than one child please complete the additional 'child detail form' (only one enrolment form per family is required)

Child 2*

Child 3*

Child 4*

GUIDELINES FOR PARENTS

Application for enrolment of your child in a Catholic School means you are choosing a Catholic education for your child. It requires your commitment to support the philosophy, values and aims of the school and a willingness to cooperate in their implementation. The School Age Care Services aligned with Catholic schools share the same values and philosophy. Your child is expected to adhere to the School's and Centre's high standards for:

- behaviour, dress and self discipline,
- participation in school activities

Checklist for parents:

All sections completed

Medication form attached (if required)

Copy of medical action plan attached (if required)

Copy of court orders attached (if required)

Please note if enrolment form is completed electronically, we will still require you to physically sign it. Once complete the service will print off the forms and organise signatures.

If you have any questions about these forms please contact:


Holy Family Care Out Of School Hours

Holy Family Primary School | Holy Family Early Learning Centre



 02 6292 0388  0418 142 432

 coosh.holyfamily@cg.catholic.edu.au

 Cnr Castleton Cres & Bugden Ave
Gowrie ACT 2904

 www.holyfamily.act.edu.au/aboutus/services/coosh

Centre use only:

Relevant attachments received

CRN details completed

Contact list updated

Billing email supplied

Details updated/created in Qikkids

BILLING INFORMATION

Our statements are available electronically. Please write the email address/es you would like to receive your statements to below (a minimum of one address is required):

Email 1:

Email 2:

PARENT/GUARDIAN INFORMATION

**Parent/
Guardian
1**

Parent/Guardian's given name:

Surname:

Date of birth:

CRN: (required to claim CCB and/or CCR)

Are you the claiming
parent that receives
the Family Assistance
Office payments

Yes
No

Relationship to child:

Mother Father
Other (please specify)

Street address & Suburb:

State:

Post code:

Home phone:

Work phone:

Mobile phone:

Email address:

Employment status:

Occupation:

Religion:

Employer:

Country of birth:

Languages other than
English spoken at home:

Are you of Aboriginal
or Torres Strait
Islander
background?:

Yes
No

**Parent/
Guardian
2**

Parent/Guardian's given name:

Surname:

Date of birth:

CRN: (required to claim CCB and/or CCR)

Are you the claiming
parent that receives
the Family Assistance
Office payments

Yes
No

Relationship to child:

Mother Father
Other (please specify)

Street address & Suburb:

State:

Post code:

Home phone:

Work phone:

Mobile phone:

Email address:

Employment status:

Occupation:

Religion:

Employer:

Country of birth:

Languages other than
English spoken at home:

Are you of Aboriginal
or Torres Strait
Islander
background?:

Yes
No

EMERGENCY CONTACTS

Emergency contact 1 (other than parents previously listed):

Contact's given name:

Surname:

Street address & Suburb:

State:

Post code:

Mobile phone:

Home phone:

Work phone:

Relationship to child/ren:

Is this person authorised to collect your child/ren from the service?:

Yes

No

Is this person authorised to consent to medical treatment for your child/ren in the event that Parent/Guardian 1 & 2 cannot be contacted?:

Yes

No

Emergency contact 2 (other than parents previously listed):

Contact's given name:

Surname:

Street address & Suburb:

State:

Post code:

Mobile phone:

Home phone:

Work phone:

Relationship to child/ren:

Is this person authorised to collect your child/ren from the service?:

Yes

No

Is this person authorised to consent to medical treatment for your child/ren in the event that Parent/Guardian 1 & 2 cannot be contacted?:

Yes

No

OTHER PEOPLE AUTHORISED TO COLLECT CHILD/REN

Contact 1

Contact's given name:

Surname:

Street address & Suburb:

State:

Post code:

Home phone:

Work phone:

Mobile phone:

Relationship to child/ren:

Contact 2

Contact's given name:

Surname:

Street address & Suburb:

State:

Post code:

Home phone:

Work phone:

Mobile phone:

Relationship to child/ren:

If there are more than 2 required please email details of other contacts through to coosh.holyfamily@cg.catholic.edu.au

MEDICAL INFORMATION

Doctor:

Doctor's contact number:

Street address:

Suburb:

State:

Post code:

Medicare Number:

OTHER CHILDREN IN APPROVED CARE

Please supply information of any other children in approved care to claim CCB and/or CCR:

Given name:

Surname:

Date of birth:

Gender:

Male

Female

Name of approved care service:

Given name:

Surname:

Date of birth:

Gender:

Male

Female

Name of approved care service:

CHILD'S DETAILS

Child's given name

Surname:

Date of birth:

Gender:

Child's CRN (different to parents)

Male

Female

Year &
Class

Please outline your child's current residential arrangements:

Street address & Suburb:

State:

Post code:

Home phone:

Religion:

Country of birth:

Languages other than
English spoken at home:

Is your child of
Aboriginal or
Torres Strait
Islander
background?:

Yes
No

Is your child fully immunised?

Yes

No

Please tick if your child:

has a court order, parenting plan/order in
place involving them

has a court order relating specifically to
residential arrangements

has a court order relating to a specific
person

Other

MEDICAL INFORMATION

Does your child suffer from any of the following:

Asthma	Fainting	High/low blood pressure
Epilepsy	Diabetes	Fits or blackouts
Heart condition	Hay fever	Sight/hearing problems
Nose bleeds	Eczema	Adverse reaction to drugs
Headaches	Allergies	Other

If you ticked any of the above please provide further information:

Signs and symptoms:

Treatment:

FOR CHRONIC OR LIFE THREATENING CONDITIONS, FURTHER FORMS DETAILING ACTIONS PLAN ETC. ARE REQUIRED

All medication is to be kept in the office or first aid kit and administered by staff. Children are not able to self administer medication.

If medication is required further medication permission forms need to be completed and signed before staff can administer medication.

AUTHORISATIONS

Medical treatment permission

I give permission for staff to give first aid treatment in the event of minor injuries to my child.

In the event of an accident or serious illness regarding my child, I give permission for staff to seek medical attention or arrange ambulance transport to the hospital if considered necessary for the welfare and safety of my child. I understand that I will be required to pay for any costs associated with transport and/or treatment of my child.

I understand that the centre is unable to care for sick children or children with a contagious illness. The centre reserves the right to exclude any child not well enough to cope with planned activities and will contact parents to arrange collection of their child.

Name:

Signature:

Date:

Fees consent

I agree to pay all fees and charges incurred while my child is enrolled, including any expenses incurred as a result of late or non payment of fees. I understand that care may be cancelled if accounts are overdue according to the service policy. I understand that in the event of financial hardship, application may be made to the Operations Manager for consideration of special arrangements. Otherwise, I understand that the centre is entitled to the recovery of outstanding fees.

Signature:

Date:

Parent guidelines and service policy & procedures

I have read the guidelines (found on the previous page) and the COOSH Parent Handbook. I agree to the responsibilities in the handbook, and apply for enrolment of my child subject to those conditions. I agree to adhere to the policies and guidelines determined by the School and Centre.

Signature:

Date:

General permissions - do you give permission for the following?:

On occasion: face paint tattoos hairspray

for your child/ren to watch PG rated programs (TV, DVD, movies)?

for your child/ren to be photographed for the purpose of displaying the centre and learning in newsletter, emails to all parents, website etc.?

your child to participate in short excursions away from the centre within surrounding areas e.g. Fadden Pines?

for us to contact you about minor injuries (anything not requiring collection of a child or further medical treatment) via text or email

Signed:

Date:

Holy Family COOSH



ALL ABOUT ME

Dear Parents,

COOSH like to collect information about each family and child to help ensure we are able to cater for the individual child - whether it is through an alternative menu or offering more support with specific activities.

Please fill out the information below and return with your enrolment to help us give your child the best experience at COOSH.

Kind regards,

The Team at Holy Family COOSH

Holy Family Primary School | Holy Family Early Learning Centre

Holy Family
COOSH



☎ 02 6292 0388 ☎ 0418 142 432

🖨 coosh.holyfamily@cq.catholic.edu.au

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Gowrie ACT 2904

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Does your child have any specific dietary requirements? (or are they a fussy eater?):

Has your child been diagnosed or is currently undergoing diagnosis for a disability or special needs?:

Are there any specific cultural or religious requirements for your child that we need to be aware of?:

Does your child have any fears or phobias?:

Can you tell us about your child's interests and hobbies?:

What does your child normally do in the morning/afternoon at home?:

Are there any special skills or hobbies or cultural traditions you would be happy to share with us at COOSH?:

Is there anything else you would like to share with us?: