

WILLIAM CLARKE LOOKING FOR BAASC

PURPOSE OF THIS FORM

If you are a parent or carer, use this form to:

- Apply for your child to enter BAASC at William Clarke College
- Make a change to an existing booking at BAASC
- Confirm BAASC 'School EasyPay' Account

FILLING IN THIS FORM

Please fill out this form manually.

- Please use black or blue pen
- Print in BLOCK LETTERS

WILLIAM CLARKE COLLEGE BEFORE AND AFTER SCHOOL CARE

M. 0409 308 835
E. BAASC@wcc.nsw.edu.au



PLEASE NOTE

The procedures that have been outlined in this information booklet are strictly enforced. Applications for variations to these procedures should be addressed, in writing, to the BAASC Co-ordinator in the first instance.

No staff members have the authority to alter any of these procedures.

The College hopes that you and your children find the Centre to be a happy and safe environment.

BEFORE AND AFTER SCHOOL CARE BOOKING FORM

Please complete this form to book or change a booking for your child by ticking the appropriate box(es).

CHILD'S DETAILS

Child's family name

First name

Commencing from

<input type="text"/>	<input type="text"/>	<input type="text"/>
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ADDING A PERMANENT BOOKING

SESSION	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
MORNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AFTERNOON	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CANCELLING A PERMANENT BOOKING

SESSION	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
MORNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AFTERNOON	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MY CHILD WILL BE AWAY (PLEASE WRITE DATES)

SESSION	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
MORNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AFTERNOON	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADD A CASUAL BOOKING

SESSION	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
MORNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AFTERNOON	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TRANSFERRING A PERMANENT BOOKING WITHIN A WEEK

PLEASE USE THE FOLLOWING INITIALS: (+T) TO TRANSFER TO AND (-T) TO TRANSFER FROM

SESSION	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
MORNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AFTERNOON	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I/We hereby give permission for appropriate medical care and attention to be given to my child in the event of any accident or emergency as set out in the Information Booklet. This includes calling an ambulance and the transportation of my child by ambulance to the hospital.

I/We understand my child may attend casual bookings, as required from time to time, in addition to the above bookings.

I/We have read and understand the BAASC booklet which includes our current schedule of fees and is part of this enrolment form.

I/We have set up a separate BAASC School EasyPay Account for direct debit of all BAASC and Vacation Care fees and confirm this set up is additional to any EasyPay set-up we may have done for College fees.

Father / Guardian 1

Date

Mother / Guardian 2

Date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Office Use Only

Parent's Code

Child's Code

<input type="text"/>	<input type="text"/>
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BEFORE AND AFTER SCHOOL CARE ENROLMENT FORM

Please complete one form per child.

1. CHILD'S DETAILS

Child's first name/s

Child's family name

Date of birth (dd/mm/yyyy)

Grade

Gender Male Female

Home address

Suburb

State

Postcode

Home phone

School attending

With whom does the student live?

Both parents Mainly Mother

Mainly Father Legal Guardian

Other (please specify)

Who is to receive BAASCC correspondence?

Both parents at one address Both parents at separate addresses

Mother only Father only

Other (please specify)

Child's cultural background

Parent's cultural background

Languages spoken at home

Cultural considerations (eg religious, dietary)

2. FAMILY / GUARDIAN INFORMATION

Mother's first name/s

Mother's family name

If not the mother, please specify relationship

Home address

Suburb

State

Postcode

Home phone

Work phone

Mobile

Email

Father's first name/s

Father's family name

If not the father, please specify relationship

Home address

Suburb

State

Postcode

Home phone

Work phone

Mobile

Email

Office Use Only

Parent's Code

Child's Code

BEFORE AND AFTER SCHOOL CARE ENROLMENT FORM CONTINUED

3. NON CUSTODIAL PARENT (A NATURAL PARENT NOT LIVING WITH THE STUDENT)

First name/s

Family name

Home address

Suburb

State

Postcode

Are there any Court orders, Parenting Orders
or Parenting plans in force in regards to the child?

Yes No

If yes, please attach a copy of the Order

4. CHILD CARE SUBSIDY

Please select one of the following:

A. I INTEND TO CLAIM CHILD CARE SUBSIDY (CCS)

Detail of parent (only one parent to be nominated for CCS purposes)

When a child is first enrolled at BAASC, the family must nominate the parent who is (or will be) registered to claim CCS. Changes to the nominated parent will only apply from when the family notifies the Centre in writing.

First name/s

Family name

Customer Reference Number (CRN)

Parent's date of birth (dd/mm/yyyy)

Child's first name/s

Child's family name

Customer Reference Number (CRN) *Please note children have their own unique CRN

Child's date of birth (dd/mm/yyyy)

OR

B. I DO NOT INTEND TO CLAIM CHILD CARE SUBSIDY (CCS)

5. OTHER AUTHORISED COLLECTORS AND EMERGENCY

Please list the names and contact details of others authorised to collect, provide authority to administer medication and consent to medical treatment in the case of an emergency when the parents are unavailable. Children will only be released to the authorised nominees.

A. FIRST AUTHORISED (IF PARENTS UNAVAILABLE)

Name

Home address

Suburb

State

Postcode

Home phone

Work phone

Mobile

Relationship to child

Authorised to collect

Authorised to authorise the Co-ordinator
to take the child offsite eg: excursion

Authorised to provide permission for medication

Authorised to consent to medical treatment

B. SECOND AUTHORISED (IF PARENTS UNAVAILABLE)

Name

Home address

Suburb

State

Postcode

Home phone

Work phone

Mobile

Relationship to child

Authorised to collect

Authorised to authorise the Co-ordinator
to take the child offsite eg: excursion

Authorised to provide permission for medication

Authorised to consent to medical treatment

BEFORE AND AFTER SCHOOL CARE ENROLMENT FORM CONTINUED

C. THIRD AUTHORISED (IF PARENTS UNAVAILABLE)

Name

Home address

Suburb State Postcode

Home phone Work phone

Mobile

Relationship to child

- Authorised to collect
- Authorised to authorise the Co-ordinator to take the child offsite eg: excursion
- Authorised to provide permission for medication
- Authorised to consent to medical treatment

6. INFORMATION ABOUT CHILD

In order to help us support and assist your child, please complete the information below.

Does your child have any learning, behaviour, educational or other special needs Yes No

Please provide details

My child has the following hobbies and interests

My child does not enjoy these activities

As a family we enjoy doing the following together

My child does enjoy eating these foods

My child does not enjoy eating these foods

7. OPTIONAL SURVEY

It would help us a great deal for our future development if you could answer these brief questions:

How did you hear about William Clarke College Before and After School Care (BAASC) and Vacation Care Centre?

- Friends
- Neighbours
- Advertising
- Other (please specify)

Please indicate the main reasons as to why you are applying for a place in BAASC

- Reputation of the BAASC
- Affordability
- Physical resources
- Centre's Programs
- Partnerships with families and community links

Please also complete the BAASC and Vacation Care Medical Details Form.

Your child will not be able to commence care without this form.

BAASC & VACATION CARE MEDICAL DETAILS

Please complete one form per child.

1. CHILD'S DETAILS

Child's first name/s

Child's family name

Date of birth (dd/mm/yyyy)

Grade

Home phone

2. FAMILY / GUARDIAN INFORMATION

Mother's first name/s

Mother's family name

If not the mother, please specify relationship

Daytime phone

Mobile

Father's first name/s

Father's family name

If not the father, please specify relationship

Daytime phone

Mobile

3. EMERGENCY CONTACTS

CONTACT 1

Name

Relationship

Daytime phone

Mobile

CONTACT 2

Name

Relationship

Daytime phone

Mobile

4. MEDICAL DETAILS

Doctor's name

Practice name

Phone

Blood group

Medicare No.

Position on card

Expiry (dd/mm/yyyy)

Private Health Fund

Fund Membership No.

Dentist's name

Practice name

Phone

5. IMMUNISATION DETAILS

Please attach a copy of your child's Immunisation History Statement

This must be in the form of:

- An Australian Childhood Immunisation Register (ACIR) Immunisation History Statement
- An ACIR Immunisation Exemption Conscientious Objection Form
- An ACIR Immunisation Exemption – Medical Contraindication Form
- An ACIR Immunisation History Form on which the immunisation provider has certified that the child is on a registered catch-up schedule

(www.health.nsw.gov.au/immunisation/pages/childcare_qa.aspx)

BAASC & VACATION CARE MEDICAL DETAILS CONTINUED

6. MEDICAL CONDITIONS

Diagnosed Medical Conditions

Abnormal Drug Reactions

Allergies

Prescribed Medications

Special Dietary Requirements (cultural, religious, additional needs)

Medications/Treatments permitted to be administered eg Ventolin, EpiPen

Other health or medical conditions or ongoing/long term illnesses not already detailed on this form

If your child has Asthma or Anaphylaxis please attach a copy of the Management Form

- Asthma Plan
 - Standard Action Plan
 - Specific Action Plan
- Anaphylaxis Plan

AUTHORISATION

I agree to Emergency First Aid Treatment being given when necessary. If I, or any of the people named above are unable to be contacted.

I,

direct the Headmaster of William Clarke College, or his delegate, to act on my behalf in providing authorisation for necessary emergency medical treatment. This authorisation extends to transportation by ambulance, administration of anaesthetic, necessary surgical operation and blood transfusion.

Signed

Date (dd/mm/yyyy)

Office Use Only

Medical Alert

Parent's Code

Child's Code