

Northside School Holiday Program General Information

Dates:

Monday 28 June – Friday 16 July 2010

Location

Burgmann Anglican School
Cnr Gungahlin Drive and the Valley Ave
Gungahlin, ACT

PHONE: 0450 840 336

EXCURSIONS: 0450 840 336

Hours: 8.00 am to 6.00 pm daily (excluding public holidays). A late fee of \$20.00 for every 15 minutes will be charged for each child collected after 6.00 pm.

Fees: \$55.00 for a single day, per child. Enrolment will not be accepted unless payment is made. No refunds will be given for cancellations without a Doctors Certificate.

Bookings: Your child/ren must be enrolled each school holidays. Advance bookings will ensure your child has a place in the Program, as places are limited. Your booking will be confirmed once processed. Please allow one week for processing. This also allows for appropriate planning, staff rostering and bookings to excursion venues. **PAYMENT MUST ACCOMPANY BOOKINGS** and refunds will only be given upon receipt of a medical certificate.

Enquires can be made at the School Age Care Administration Office on 6293 6500 or you may email csc@commsatwork.org

Child Care Benefit:

We encourage all families to be assessed for CCB eligibility, as most families are entitled for minimum assistance. Parents can either claim CCB entitlement as a lump sum at the end of the financial year.

Families can contact the **Family Assistance Office** by visiting a Centrelink, Medicare or ATO office. Alternatively Family Assistance contact number is **13 61 50** or visit their website www.familyassist.gov.au

Full payment will be required until your Assessment Notice has been received; adjustments will be made on receipt of the notice from the Family Assistance Office.

Excursion Fees: Excursions on the program, unless otherwise mentioned, are part of the daily activities and are not optional. Permission is required for all excursions. (Outdoor excursions are liable to change at short notice depending on weather conditions.)

Meals and Snacks: A nutritious packed morning tea, lunch and water bottle are to be provided by families. The program provides afternoon tea.

Attendance: If your child/ren are unable to attend the program due to illness or other reasons you need to contact the School Age Care Administration on **(02) 6293 6500** or email: csc@commsatwork.org

Eligibility: According to Government guidelines, only children attending **Primary School** are eligible to attend the Holiday Program. Kindergarten children must be enrolled at school to attend the School Holiday Program.

Sun Protection: Communities@Work Programs are SunSmart services. We implement a **"No Hat, No Play"** rule from August to May. Children are only allowed outside wearing a "wide brimmed", "legionnaire" or "bucket style" hat and **clothing that covers their shoulders**. No singlets please.

Contact Details:

School Age Care Administration Office is located at Tuggeranong Community Centre, 245 Cowlshaw Street, Greenway, ACT.

Postal Address: PO Box 1066
Tuggeranong ACT 2901

Telephone: (02) 6293 6500

Facsimile: (02) 6293 3978

Email: csc@commsatwork.org

Web: www.commsatwork.org

Northside School Holiday Program Program - Kindergarten to Year 6 Enrolment Form 28 June - 16 July 2010

PO BOX 1066, TUGGERANONG ACT 2901

Telephone: (02) 6293 6500

FAX: (02) 6293 3 978

EMAIL: csc@commsatwork.org

WEB ADDRESS: www.commsatwork.org

ENROLMENTS – (FOR PRIMARY SCHOOL CHILDREN ONLY) PAYMENT TO BE MADE AT TIME OF ENROLMENT

Parent/Guardian must complete this form. Please complete ALL INFORMATION on BOTH SIDES of this application.

Centrelink Reference Number of Parent/Carer Claiming CCB: - -

Please call the Family Assistance Office (FAO) on 13 61 50 to obtain your Centrelink Reference Number (CRN) if you do not have one. If you **do not** intend to claim Child Care Benefit (CCB) to reduce your fees, we still require your CRN to comply with government reporting requirements.

CHILD/REN'S DETAILS							
Child's Full Name (1):				Child's Full Name (2):			
Date of Birth:		Male/Female		Date of Birth:		Male/Female	
Child's CRN Number				Child's CRN Number			
Address:							
Allergies YES NO		Asthma YES NO		Allergies YES NO		Asthma YES NO	
Medical condition YES NO		Medication YES NO		Medical condition YES NO		Medication YES NO	
Does this child have any additional or specific needs that we should be aware of which may require support? YES NO				Does this child have any additional or specific needs that we should be aware of which may require support? YES NO			
If Yes to above, please explain: eg Epipen, Asthma Plan etc. (please attach plan)				If Yes to above, please explain: eg Epipen, Asthma Plan etc. (please attach plan)			
Please note any infectious illness eg: Chicken pox, measles, mumps etc:				Please note any infectious illness eg: Chicken pox, measles, mumps etc:			

Office Use Only (Please initial and date)

Entered onto Qikkids	DD / CC	Copied	Confirmation	CCMS Enrolled	Statement:
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CHILD/REN'S DETAILS			
Child's Full Name (3):		Child's Full Name (4):	
Date of Birth:	Male/Female	Date of Birth:	Male/Female
Child's CRN Number		Child's CRN Number	
Address:			
Allergies	YES NO	Asthma	YES NO
Medical condition	YES NO	Medical condition	YES NO
Does this child have any additional or specific needs that we should be aware of which may require support?		Does this child have any additional or specific needs that we should be aware of which may require support?	
If Yes to above, please explain: eg Epipen, Asthma Plan etc. (please attach plan)		If Yes to above, please explain: eg Epipen, Asthma Plan etc. (please attach plan)	
Please note any infectious illness eg: Chicken pox, measles, mumps etc:		Please note any infectious illness eg: Chicken pox, measles, mumps etc:	
PARENT/GUARDIAN DETAILS (2)			
Surname		First name	DATE OF BIRTH
CRN Number		Relationship to child	
Address:			
Mobile phone		Home phone	Work phone
E-mail		Place of Employment	
Is this person authorised to collect your child/ren? YES NO			
PARENT/GUARDIAN DETAILS (2)			
Surname		First name	DATE OF BIRTH
CRN Number		Relationship to child	
Address:			
Mobile phone		Home phone	Work phone
E-mail		Place of Employment	
Is this person authorised to collect your child/ren? YES NO			

ADDITIONAL ADULT CONTACT DETAILS (must be over 18 years old)

Please nominate 2 adults (other than the parent/guardian listed above) to contact in case of emergency:

Adult 1:

Surname	First name	Relationship to child
Mobile phone	Home phone	Work phone
Is this person authorised to collect your child/ren?		YES NO

Adult 2:

Surname	First name	Relationship to child
Mobile phone	Home phone	Work phone
Is this person authorised to collect your child/ren?		YES NO

BACKGROUND INFORMATION

Does your child attend another program?	Yes	No	Name of Program		
Are you an Aboriginal or Torres Strait Islander Family?	Yes	No	Do you give permission for your children to be photographed during the program?	Yes	No
Do you give permission for your child to watch PG rated movies under the supervision of Staff during the program?	Yes	No	Are there any court orders that affect any of the children listed on this enrolment application? (Please attach documents)	Yes	No
What is the primary language spoken at home?			Cultural background		
Are there any specific instructions regarding cultural practices:					

CHILD CARE BENEFIT (CCB) (Please Tick)

I would like to claim CCB as reduced fees.
Please Note: You must register with the FAO on 13 61 50

MEDICAL INFORMATION

Name of Family Doctor:	Phone Number:
Is your child/ren Immunised? YES NO Immunisation records to be provided.	Parents signature:

Please tick the days you would like your child/children to attend the School Holiday Program

Childs Name		MON	TUE	WED	THU	FRI
Child 1	Week One	28/6	29/6	30/6	1/7	2/7
	Week Two	5/7	6/7	7/7	8/7	9/7
	Week Three	12/7	13/7	14/7	15/7	16/7

Child 2	Week One	28/6	29/6	30/6	1/7	2/7
	Week Two	5/7	6/7	7/7	8/7	9/7
	Week Three	12/7	13/7	14/7	15/7	16/7

Child 3	Week One	28/6	29/6	30/6	1/7	2/7
	Week Two	5/7	6/7	7/7	8/7	9/7
	Week Three	12/7	13/7	14/7	15/7	16/7

Child 4	Week One	28/6	29/6	30/6	1/7	2/7
	Week Two	5/7	6/7	7/7	8/7	9/7
	Week Three	12/7	13/7	14/7	15/7	16/7

ACCOUNTS (please tick a box)

Name of Person responsible for payment of account:	I would like to receive my account mail: <input type="checkbox"/>
I would like to receive my account by email: <input type="checkbox"/>	Email Address:

PARENT STATEMENT FORM

Information required if you have a Current Assessment Notice from Family Assistance Office and there are siblings listed on this Assessment Notice and those siblings attend another approved Long Day Care, Family Day Care or School Age Care program. Please fill out the details of the other siblings listed and the name of the program so the higher percentage of CCB can be applied to your fees.

	Child 1	Child 2	Child 3	Child 4
Surname				
Given Names				
Date of Birth				
Other program name				

How many of your children attend approved Long Day Care, Family Day Care or School Age Care Programs or any combination of these services in the same week? ()

REFERENCE BASE

Why did you choose this program for your child/ren?

What was your initial source of information on the centre?

Yellow Pages () White Pages () Friend () Another Parent ()
 Internet () Signage on Location () Other () Specify:

I the undersigned:

1. I/we agree to pay all fees and charges by the due date for any account rendered. I/we understand that in the event of financial hardship, special arrangements may be made on application to the Director. I/we understand additional costs may be incurred if referred to a Debt Recovery Agency.
2. I/we understand that the booking will be cancelled if the account remains outstanding and will be forwarded to the Debt Recovery Agency.
3. I/we agree to indemnify Communities@Work and any person associated with the program in relation to any claim for damages as a result of an accident or injury to my child unless it is the direct result of negligence on the behalf of Communities@Work or associated persons.
4. In the event of an accident or illness requiring emergency medical treatment, I authorise Communities@Work staff to seek emergency medical treatment for my child should this be considered necessary. I agree to meet any medical and ambulance expense incurred.
5. I/we give permission for the administration of a bronchodilator using an inhaling device if my child should suddenly collapse and/or have difficulty in breathing.
6. I/we understand that Child Care Benefit cannot be applied to my fees if my child is absent on his/her first and last day(s) and that full fees will be charged.
7. I/we understand that a late fee of \$20.00 per child for every fifteen minutes will be charged for children picked up after 6.00pm
8. I/We understand no refund will be given on cancelled days unless a doctor's certificate is provided.
9. The information I have provided on this form is correct.

Parent/guardian signature:	Date:
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OPTIONAL

10. I consent to my child/ren being the subject of observations for program development.
Parent Signature _____
11. I give permission for my child/ren to be photographed or videoed during various activities for Quality Assurance purposes.
Parent Signature _____
12. I give permission for my child/ren to participate in incursions/excursions from the program within the local community. Families will be informed separately of any excursions not in local area.
Parent Signature _____

IMPORTANT! – Please note that you will be charged for the days you book. In the event that you do not use your booked days (due to changed plans, sickness, etc) you are still required to pay for your booking unless a Doctors Certificate is provided.

Your booking will be confirmed once processed. Please allow one week for processing.

OFFICE USE ONLY

Amount Paid		
Payment Type		
Date:		
Received By:		

