PORT KENNEDY ASSOCIATION INCORPORATED
PO Box 114, Thursday Island QLD 4875
Ph: 07 4069 2306, Fax: 07 4069 1977
Website: www.pka.org.au

AFTER SCHOOL CARE ENROLMENT FORM 2016

Port Kennedy Association Inc. After School Care Fees are $2.00 per/day and an initial deposit of $40.00 *(advance one month credit payment)* will be needed at the time of enrollment. Your child will need to be in credit $20.00 *(two weeks)* minimum at all times. As of 2016 once your child/s have obtained fulltime enrollment with the After School Care program this fee will be charged to your child/s account even if your child/s is absent for the day, week or a month.

Payments

After School Care **fees must be paid either weekly, fortnightly or monthly**. If Port Kennedy Association receives NO PAYMENT within that month, a **Debt Recovery of Outstanding Fees Letter** will be sent out to your nominated address or PO Box stating the procedures that will be taken and this may lead to termination of your child/s After School Care Enrollment. Payments can be made at the Port Kennedy Office, we accept cash, EFTPOS and also direct deposit into the After School Care Account.

Fee Requirements

- ✓ NO out-standing Fees
- ✓ Regular payments

BUS DROP OFF TIME

As a part of the Port Kennedy Association Inc. After School Care Program we offer FREE daily drop-off for all child/s attending the After School Care Program, drop-off are between 5:00pm – 6:00pm on Monday – Friday to your child/s nominated address stating on their enrollment form. If you would wish to change your child/s drop-off address please advise the Port Kennedy Office via email or phone call, we won't' accept any messages provided through your child/s.

NOTE: Please take a moment to read the above information along with the After School Care Program Parent Handbook that was provided with the After School Care enrollment form before dating and signing the back page.

Please ensure all information that is collected by the Port Kennedy Office are correct and up-to date. If any of the following details *(e.g. contact details)* change please inform the Port Kennedy Office at once (07) 4069 2306.

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CONFIDENTIAL

Child's Last Name: ____________________________ **Middle Name:** _________________________________

Child's First Name________________________________ **Sex:** ☐ **Male** ☐ **Female**

Child's Address:____

Does your child speak any languages other than English at home? ☐ **No** ☐ **Yes**

If yes, what language/s are spoken at home:____

Date of birth :______________________________ **Starting Date:** ____________________________

ATTENDANCE (Please tick):	**After School Care**
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

School Child Attends - …………………………………………………………...

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HEALTH

Allergies: (Causes/symptoms/medication)____

Does your child suffer from asthma? ____

Is your child receiving regular medication? Give details. List any side effects.__________________

____

Is your child a carrier of any infectious disease? (eg Hepatitis B). If yes, what steps have been taken by you/child's doctor to reduce the possibility of transmitting the infectious disease?

____

History of any major illness/operation:____

____

Is your child restricted from any activities (eg swimming, high level physical activity)? If yes, please give details. Outline any conditions that affect your child's participation in specific activities:
____

____

DIET / FOOD

Any Food allergies: ____

Any Dietary restrictions / Special Requirements: _______________________________________

FAMILY DOCTOR: ____

Address: ____ ***Phone:*** ______________________________

Medicare Number: __________________________________

I / We give permission to Port Kennedy Association to contact Family Doctor? ☐ ***Yes*** ☐ ***No*** ☐ ***Other Reasons***

____

(Tick more than one, if relevant)

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MOTHER / GUARDIAN 1

Title:_____ Name: First:________________________ Last:__________________________________

Address:____

Postal Address: ____

State:________________ Postcode:_________________

Email Address: ____

Home Phone:________________________ Mobile Phone:__________________________________

Work Phone:________________________ Occupation/Course:_____________________________

Employer :____

☐ ***Aboriginal*** ☐ ***Torres Strait Islander*** ☐ ***Not Aboriginal or Torres Strait Islander***
(Tick more than one, if relevant)

FATHER / GUARDIAN 2

Title:______ Name: First:____________________________ Last_____________________________

Address:____

Postal Address: ____

State:________________ Postcode:_________________

Home Phone:___________________________ Mobile Phone:________________________________

Work Phone:___________________________ Occupation/Course:___________________________

Employer :____

☐ ***Aboriginal*** ☐ ***Torres Strait Islander*** ☐ ***Not Aboriginal or Torres Strait Islander***
(Tick more than one, if relevant)

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EMERGENCY CONTACTS (other than parent (s) / guardian)

Contact 1:____

Address:____

Home Phone:______________________________ ***Work Phone:***______________________________

Mobile Phone:____________________________ ***Relationship to child:***_______________________

Contact 2:____

Address:____

Home Phone:______________________________ ***Work Phone:***______________________________

Mobile Phone:____________________________ ***Relationship to child:***_______________________

AUTHORISATION FOR COLLECTION OF CHILD (other than parent (s) / guardian)

Authorised person 1

Name____ ***Relationship to child***_________________________

Address:____

Preferred contact # ______________________ ***Alt contact #*** _______________________________

Authorised person 2

Name____ ***Relationship to child*** _________________________

Address:____

Preferred contact #____________________________ ***Alt contact #***______________________________

Details of any court orders affecting the custody of the child*:* ______________________________

____

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PARENTAL CONSENT

MEDICAL

In the case of an accident, or any other emergency resulting in the need for immediate medical or dental attention, I / we hereby consent to the Coordinator or her / his designated representatives/s to obtain such ambulance, medical, dental, and / or hospital assistance as is required and agree to meet all expenses thereby incurred.

VIDEOING/PHOTOGRAPHS

I / We consent to my / our child being videoed or photographed in any video or photograph conducted or commissioned by the service for marketing / promotional and reporting purposes.

USE OF INFORMATION

I / We give the service my / our consent to use the information contained in this form, in keeping with the Information Handling Policy and the other Policies and Procedures of the Service.

POLICIES AND GUIDELINES

I / We have read the rules, regulations and requirements pertaining to the provision of after school and vacation care in this form and in the separate *Parent Handbook*. I / We acknowledge that I / we fully understand and agree to abide by all conditions appearing in this form, in any notices, and the Handbook, as amended from time to time. I / we declare that the information given above is accurate and agree to notify the Coordinator or the centre immediately there is any change to the above information.

Any Exceptions? (Please indicate if you do not give consent to any of the above)

Signature of parent / guardian: ______________________________________

Date: ______________________________________