MACKAY CHRISTIAN COLLEGE

We Love | We Care | We Learn

ABN 22 010 555 389

OUTSIDE SCHOOL HOURS CARE - ADDITIONAL SIBLINGS APPLICATION

Please use BLOCK letters completing this form.

Name of Child (3):		Year Level:	
Name of Child (4):		Year Level:	

CHILD 3 INFORMATION

Legal Given Names: Date of Birth: / /

Legal Surname: Sex: M ☐ F ☐ Age:

Name known as (if different) eg. preferred name:

Residential Address: Post Code:

Child's CRN (Centrelink No. for CCS purposes) Immunisation Current? Yes ☐ No ☐ **Must supply proof of immunisation**

Are there any details which may have an influence on your child's attendance or may be relevant to their enrolment at OSHCare?

If **yes**, please indicate the details briefly:

Does your child have any behavioural difficulties? Yes ☐ No ☐ If **yes**, please provide details:

Nationality

In which country was the child born? What is the Nationality of the child?

Is the child of **Aboriginal or Torres Strait Islander (TSI)** origin? **Yes** ☐ Aboriginal ☐ TSI (if both, tick both boxes) ☐ **Neither**

Language

Does the child speak a language other than 'Standard Australian English' at home? Yes ☐ No ☐

If **yes**, what language: (If more than one language, please indicate the language that is spoken most often)

Residency

What is the child's residency status? Australian Citizen ☐ New Zealand Citizen ☐ Other:

Permanent Resident ☐ Temporary Visa holder ☐ ***A copy of Residency/Visa must be supplied***

If born overseas, on what date did the child **arrive** in Australia? / /

If the child is a Permanent Resident or Temporary Visa holder please provide the following information:

Visa type: Current Visa Sub-Class no: Visa expiry date: / /

Culture/Religion

Are there special requirements which may arise from the culture or religion of the family? Yes ☐ No ☐ If **yes**, please provide details:

Medical Information

Has your child been diagnosed with a medical condition? eg. Asthma, Diabetes / ADD, Physical Impairment Yes ☐ No ☐

If **yes**, please provide details:

If **yes**, is your child taking medication for this? Yes ☐ No ☐ If **yes**, Type and Dosage:

Allergic Reaction Management Plan

Does your child have any allergies eg. Latex (Bandaids), Nuts, Eggs, Animals, Dairy Products, Bee Stings etc? Yes ☐ No ☐

If **yes**, please provide details:

*A copy of the child's **Allergy Management Plan** and/or **Emergency Action Plan** completed by a **Medical Practitioner** must be provided.*

CHILD 4 INFORMATION

Legal Given Names: Date of Birth: / /

Legal Surname: Sex: M ☐ F ☐ Age:

Name known as (if different) eg. preferred name:

Residential Address: Post Code:

Child's CRN (Centrelink No. for CCS purposes) Immunisation Current? Yes ☐ No ☐ **Must supply proof of immunisation**

Are there any details which may have an influence on your child's attendance or may be relevant to their enrolment at OSHCare?

If **yes**, please indicate the details briefly:

Does your child have any behavioural difficulties? Yes ☐ No ☐ If **yes**, please provide details:

Nationality

In which country was the child born? What is the Nationality of the child?

Is the child of **Aboriginal or Torres Strait Islander (TSI)** origin? **Yes** ☐ Aboriginal ☐ TSI (if both, tick both boxes) ☐ **Neither**

Language

Does the child speak a language other than 'Standard Australian English' at home? Yes ☐ No ☐

If **yes**, what language: (If more than one language, please indicate the language that is spoken most often)

Residency

What is the child's residency status? Australian Citizen ☐ New Zealand Citizen ☐ Other:

Permanent Resident ☐ Temporary Visa holder ☐ ***A copy of Residency/Visa must be supplied***

If born overseas, on what date did the child **arrive** in Australia? / /

If the child is a Permanent Resident or Temporary Visa holder please provide the following information:

Visa type: Current Visa Sub-Class no: Visa expiry date: / /

Culture/Religion

Are there special requirements which may arise from the culture or religion of the family? Yes ☐ No ☐ If **yes**, please provide details:

Medical Information

Has your child been diagnosed with a medical condition? eg. Asthma, Diabetes / ADD, Physical Impairment Yes ☐ No ☐

If **yes**, please provide details:

If **yes**, is your child taking medication for this? Yes ☐ No ☐ If **yes**, Type and Dosage:

Allergic Reaction Management Plan

Does your child have any allergies eg. Latex (Bandaids), Nuts, Eggs, Animals, Dairy Products, Bee Stings etc? Yes ☐ No ☐

If **yes**, please provide details:

*A copy of the child's **Allergy Management Plan** and/or **Emergency Action Plan** completed by a **Medical Practitioner** must be provided.*