It's about you. Always!
Communities@Work

ABN 19 125 799 859

Junior School Holiday Program
Gilmore

Dates
Monday 12 – Friday 23 April 2010

Location
Gilmore Family Cottage, Gilmore Primary School, Heagney Crescent, Gilmore
Program: 0405 506 575
Excursions: 0405 506 575

Hours: 8.00 am to 6.00 pm daily (excluding public holidays). Sessional hours are 8.00 am – 1.00 pm or 1.00 pm to 6.00 pm. A late fee of $20.00 for every 15 minutes will be charged for each child collected after 6.00pm or after 1pm for morning session.

Fees: $52.00 for a single day or $30.00 per session, per child. Enrolment will not be accepted unless payment is made. No refunds will be given for cancellations without a Doctor's 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. This also allows for appropriate planning, roster of staff and bookings to excursion venues. **PAYMENT MUST ACCOMPANY BOOKINGS** and refunds will only be given upon receipt of a medical certificate.

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

Child Care Benefit:
We encourage all families to be assessed for CCB eligibility, as most families are entitled to minimum assistance. Parents can either claim CCB entitlement as a lump sum at the end of the financial year or can contact the **Family Assistance Office** by visiting a Centrelink, Medicare or ATO office. Alternatively, the 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 and afternoon tea, lunch and drinks are to be provided by families.

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: sac@commsatwork.org

Eligibility: This Program is designed specifically for children in kindergarten and Year 1.

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 style" or "bucket style" hat and clothing that **covers their shoulders.** No singlets please.

Contact Details:
The School Age Care Administration Office is located at Tuggeranong Community Centre, 245 Cowlishaw Street, Greenway , ACT.

Postal Address: PO Box 1066
TUGGERANONG ACT 2901

Telephone: (02) 6293 6500
Facsimile: (02) 6293 3978
Email: sac@commsatwork.org
Web: www.commsatwork.org

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Junior School Holiday Program
Enrolment Form
Gilmore: 12 – 23 April 2010

PO Box 1066 TUGGERANONG ACT 2901 TELEPHONE: (02) 62936500 FAX: (02) 6293 3978
EMAIL: sac@commsatwork.org WEB ADDRESS: www.commsatwork.org

PAYMENT TO BE MADE AT TIME OF ENROLMENT

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

Parent's Centrelink Reference Number: ☐☐☐-☐☐☐-☐☐☐☐

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 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 on Qikkids	DD / CC / D Deposit	Copied	Confirmation sent

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		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:			

PARENT/GUARDIAN DETAILS			
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			
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 mark the days you would like your child/children to attend the School Holiday Program

Please circle dates required

Sessional hours	Sessional hours	Full Day
8.00am to 1.00pm ☐	1.00pm to 6.00pm ☐	8.00am to 6.00pm ☐

Childs Details	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri
Child 1	12/4	13/4	14/4	15/4	16/4	19/4	20/4	21/4	22/4	23/4
Child 2	12/4	13/4	14/4	15/4	16/4	19/4	20/4	21/4	22/4	23/4
Child 3	12/4	13/4	14/4	15/4	16/4	19/4	20/4	21/4	22/4	23/4
Child 4	12/4	13/4	14/4	15/4	16/4	19/4	20/4	21/4	22/4	23/4

ACCOUNTS (please tick a box)

Name of Person responsible for payment of account.	I would like to receive my account mail: ☐
I would like to receive my account by email: ☐	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
Family Name				
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 (   ) Signature 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 a late fee of $20.00 per child for every fifteen minutes will be charged for children picked up after 6.00pm

7. I/We understand no refund will be given on cancelled days unless a doctor's certificate is provided.

8. The information I have provided on this form are correct.

Parent/guardian signature:	Date:

OPTIONAL

9. I consent to my child/ren being the subject of observations for program development.

   Parent Signature ____

10. I/we give permission for my child/ren to be photographed or videoed during various activities for Quality Assurance purposes.

    Parent Signature ____

11. I give permission for my child/ren to participate in excursions from the centre within the local community. Families will be informed separately of any excursions not in the 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.

OFFICE USE ONLY

Amount Paid		
Payment Type		
Received By:		
Date:		

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Communities@Work

Junior Holiday Program

Automatic Payment Option Authority

Please fill in all details to authorise payment. (If details not completed, payment will not be processed)

I / We ____
(Insert full name)

Authorise Communities @ Work School Age Care to take payment for Junior Holiday Program fees.

Holiday Program fees are to be paid in advance. Please nominate the date you would like the payment to be charged to your account.

____

SIGNATURE OF ACCOUNT HOLDER **DATE:**

PAYMENT OPTION 1

AUTOMATIC CREDIT CARD AUTHORISATION - ***Please complete the details below.***

I authorise C@W to debit the following credit card: ❑ Mastercard ❑ Visa (Please check a box)

Credit Card No:																	Exp

Cardholder's Name: Cardholders Signature:

Date payment to be charged to your card:

Please advise any changes to your Credit Card details. Costs may be charged by the bank if transactions are rejected or dishonoured. Any costs charged to Communities@Work will be transferred to your childcare account.

PAYMENT OPTION 2

DIRECT DEBIT REQUEST – ***Client's Authority please complete the details below.***

Name of Financial Institution: Branch:

Name of Account Holder/s:

BSB Number: Bank Account Number:

Date payment to be charged to your account:

Customer's Signature (If joint account all signatures may be required):

It is essential that the bank details are correct. Costs may be incurred by you if transactions are rejected or dishonoured. Any costs charged to Communities@Work will be transferred to your child care account.