

Care at St Thomas School Holiday Program General Information

Dates:

Monday 12 – Friday 23 April 2010

Location

Care at St Thomas the Apostle Primary School
Boddington Crescent,
KAMBAH, ACT

Program: 0409 989 648

Mobile: 0410 023 740

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: \$52.00 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. 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.

Enquires 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 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 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: 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:

The 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: sac@commsatwork.org

Web: www.commsatwork.org

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	Medication	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?	
YES NO		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 (1)			
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			Parents signature:		
Immunisation records to be provided.					

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

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Childs Name	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

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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 () 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:
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OPTIONAL

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

Parent Signature _____

10. I 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		
Date:		
Received By:		

