

**Y- West Vacation Care
Christmas 2011/2012 BOOKING FORM**

OFFICE USE ONLY
DATE RECEIVED:

STAFF INITIALS:

Centerlink Registered Parent :CRN.....

Child/ren's Home Telephone:

Mother's Name:DOB.....

Mother's Home Ph.: Mobile: Email:.....

Work Ph: Occupation Employer:.....

Residential Address:

Suburb: Post Code:

Father's Name:DOB.....

Father's Home Ph.: Mobile: Email:.....

Work Ph: Occupation: Employer:.....

Residential Address:

Suburb: Post Code:

FIRST CHILD

Full Name:CRN.....

Date of Birth: Age: Gender: Male Female

Grade: School currently attending:.....

Religion/Cultural belief:..... Blood type (if known).....

SECOND CHILD

Full Name:CRN.....

Date of Birth: Age: Gender: Male Female

Grade: School currently attending:.....

Religion/Cultural belief:..... Blood type (if known).....

THIRD CHILD

Full Name:CRN.....

Date of Birth: Age: Gender: Male Female

Grade: School currently attending:.....

Religion/Cultural belief:..... Blood type (if known).....

EMERGENCY CONTACT OTHER THAN A PARENT (MUST BE PERMITTED TO COLLECT CHILD/REN)

Name: Relationship to Child/ren:

Telephone Number: (H) (W) (M)

PEOPLE AUTHORISED TO COLLECT MY CHILD/REN OTHER THAN PARENT OR EMERGENCY CONTACT.

Name: Relationship to Child/ren: Telephone Number:

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Name: Relationship to Child/ren: Telephone Number:

I WISH TO BOOK MY CHILD/REN FOR THE FOLLOWING DAYS:

WEEK ONE	WEEK TWO	WEEK THREE
<input type="checkbox"/> Monday 12 th December <input type="checkbox"/> Tuesday 13 th December <input type="checkbox"/> Wednesday 14 th December <input type="checkbox"/> Thursday 15 th December <input type="checkbox"/> Friday 16 th December	<input type="checkbox"/> Monday 19 th December <input type="checkbox"/> Tuesday 20 th December <input type="checkbox"/> Wednesday 21 st December <input type="checkbox"/> Thursday 22 nd December <input type="checkbox"/> Friday 23 rd December	The Centre is Closed for a week and a day for Christmas and New Years period.
WEEK FOUR	WEEK FIVE	
<input type="checkbox"/> Tuesday 3 rd January <input type="checkbox"/> Wednesday 4 th January <input type="checkbox"/> Thursday 5 th January <input type="checkbox"/> Friday 6 th January	<input type="checkbox"/> Monday 9 th January <input type="checkbox"/> Tuesday 10 th January <input type="checkbox"/> Wednesday 11 th January <input type="checkbox"/> Thursday 12 th January <input type="checkbox"/> Friday 13 th January	<input type="checkbox"/> Monday 16 th January <input type="checkbox"/> Tuesday 17 th January <input type="checkbox"/> Wednesday 18 th January <input type="checkbox"/> Thursday 19 th January <input type="checkbox"/> Friday 20 th January

PARENT'S DECLARATION (MUST BE SIGNED FOR BOOKING TO BE ACCEPTED)

I appreciate that, whilst every care will be taken, the YMCA, its staff and leaders, or anyone connected with the program cannot be held responsible for personal injury or loss or theft of property. I authorise the Program Co-ordinator to obtain for my child(ren) any necessary medical attention at my expense and to notify me as soon as possible. I give my permission to call an ambulance if staff deem necessary and understand I will be responsible for any costs incurred. I also authorise staff to transport my child(ren) by vehicle to a doctor's surgery. Furthermore, I give permission for my child(ren) to participate in any excursions and activities planned as part of this Vacation Care Program. I understand that if I do not wish for my child to participate in an activity I must notify the staff in writing. I understand that at the Co-ordinators discretion, activities may be changed due to unforeseeable circumstances. I have read and understood & accept the conditions of the payment of fees and bookings and cancellation policies.

Parent/Guardian Date:

MEDICAL DETAILS Please list your child/rens medical problems (if any) e.g. behavioural disorders, asthma, diabetes, allergies, etc. & attach any management plans if applicable. Plans are archived at the end of each holiday.

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My child/ren take the following medication (please state dosage and time):

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On your first day at the centre, please take the time to read our Medical Policy which states that written authorisation to administer any medication must be received prior to the time required. All medications, including asthma sprays, must be given to the Co-ordinator. Staff will not be held responsible for any self administering of asthma preventive sprays, etc.

Doctor's Name: Phone No.:
 Medicare No.:

CHILD CARE BENEFIT

Have you registered for the Child Care Benefit? Yes No

What method of Child Care Reduction are you Claiming? Centre Rebate Lump Sum (once a year)
 Quarterly Rebate Fortnightly Rebate to Bank Account

Do you have any other children attending a Child Care Centre? If yes how many Yes No

PAYMENT DETAILS: Send completed application form before September 16th

I will be paying my fees with: Cash Cheque Eftpos B-Pay
 OR Please debit my Bankcard/MasterCard/Visa card for the total of fees incurred over the Vacation Care Program.

Number: _____ Expiry Date: ____/____/____

Name of Card Holder (please print):

Signature of Card Holder: Date:

PHOTOGRAPHIC RELEASE

I do / do not give permission for my child's photograph to be used for promotional purposes.

HOW DID YOU HEAR ABOUT YMCA VACATION CARE?

Internet Newspaper School Newsletter Friend Previous User of Service

MAILING LIST Please tick the box if you wish to be added to our mailing list