



MOUNT BARKER
WALDORF SCHOOL

Outside School Hours Care / Vacation Care

Parent Details:

Name:		Mobile:	
Address:			
Email:			
CRN:		Date of birth:	

Student 1 Details:

School:	
Name:	
Class:	
CRN:	
DOB:	

Student 2 Details:

School:	
Name:	
Class:	
CRN:	
DOB:	

Student 3 Details:

School:	
Name:	
Class:	
CRN:	
DOB:	

Student 4 Details:

School:	
Name:	
Class:	
CRN:	
DOB:	

Emergency Contact 1 Details:

Name:		Mobile:	
Address:			

Emergency Contact 2 Details:

Name:		Mobile:	
Address:			

Medical Information: (please complete separate form for each child)

CONDITION	DETAILS	
Heart Problems		
Respiratory Problems		
Allergies		
Travel Sickness		
Blood Pressure		
Phobias		
Bed Wetting		
Operations		
Recent Illness		
Drugs Required		
Permission to administer		(only to be given when required for severe pain e.g. fractures)
Panadol		
Drug Reaction		
Medicare Number		
Any dietary information		<i>if yes, please detail</i>
Other Information		

I give my permission for the OSHC Director to access personal family information kept on record at the school.

Parent Name		Parent Signature	