Complete the following details to help us get to know your child and provide the best possible service.

All information supplied is confidential – see ‘Your information, It’s Private’ brochure for details.

|  |  |  |
| --- | --- | --- |
| **Personal details** | | |
| Last Name  . | First Name  . | Gender  Male  Female |
| Street Address  . | Suburb  . | Postcode  . |

|  |  |  |  |
| --- | --- | --- | --- |
| Childs mobile phone  . | Date of birth \_\_\_ /\_\_\_ /\_\_\_ | Aboriginal:  Yes  No | Swimming Ability:  Non-swim  25-50m  50-200m  200m+ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Activity information: | | | | |
| **Date** | **Activity** | **Please**  **Tick** | **Cost per person** | **Office use** |
| Tuesday 30 June | Laser Tag and Lake Pertobe |  | $40.00 |  |
| Thursday 2 July | Disney One Ice |  | $40.00 |  |
| Tuesday 7 July | Paintballing Mt Gambier (complete waiver form) |  | $40.00 |  |
| Thursday 9 July | The Park – Indoor Skate Park (complete waiver form) |  | $40.00 |  |
|  |  | **TOTAL** | $ |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medical information** | | | |  |
| Ambulance cover:  Yes  No | | Healthcare card:  Yes  No | | Healthcare card number:  . |
| Medicare No:  . | | Tetanus  Yes  No | | Year of immunisation:  . |
| Asthmas\* | No | Yes | . | |
| Epilepsy\* | No | Yes | . | |
| Diabetes | No | Yes | . | |
| Allergies\* | No | Yes | . | |
| Heart condition | No | Yes | . | |
| Travel illness | No | Yes | . | |
| Impaired vision | No | Yes | . | |
| Impaired hearing | No | Yes | . | |
| Injury | No | Yes | . | |
| Disability | No | Yes | . | |
| Asperger syndrome | No | Yes | . | |
| Autism | No | Yes | . | |
| ADHA/ ADD | No | Yes | . | |
| Dietary requirements | No | Yes | . | |
| Behavioural issues | No | Yes | . | |
| Other | No | Yes | . | |
| \***You must provide an ACTION PLAN completed by a doctor with a current photo of child attached** | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **PARENT / GUARDIAN DETAILS** | | | | | | | |
| Last Name  . | | First Name  . | | | | Relationship to child  . | |
| Street Address  . | | | Town  . | | | | Postcode  . |
| Mobile Phone  . | Alternate Phone  . | | | Email  . | | | |
| **ADDITIONAL ADULT CONTACT DETAILS (must be over 18 years of age)** | | | | | | | |
| Last Name  . | | First Name  . | | | | Relationship to child  . | |
| Mobile Phone  . | | Home Phone  . | | | Work Phone  . | | |

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| --- | --- | --- |
| **Personal details** | | |
| Last Name  . | First Name  . | Gender  Male  Female |

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| **Media consent** | | |
| At the request of Western District Health Service, I hereby consent to the reproduction of the photographs in which my child appears, in any Western District Health Service publications, displays or paid advertising related to the promotion of the health service; also in any publications (including internet, newspapers and magazines) produced by other agencies to which Western District Health Service might supply the photographs for the general purpose of the promotion of the Health Service. | | |
| Parent/ guardian name  . | Parent/ guardian signature  . | Date  \_\_\_ /\_\_\_ /\_\_\_ |

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| **PARENT/GUARDIAN DECLARATION (please tick)** | | |
| I give consent for my child to take part in the activity/s by Western District Health Service (WDHS). I have read and fully understand all the additional information. | | |
| I agree that WDHS will not incur any responsibility or liability for any accident / injury / damage to / loss of property of my child during the activity. | | |
| I authorise WDHS to obtain medical/ambulance assistance in the case of emergency involving my child. | | |
| I understand if my child is identified with a potential communicable disease a nominated guardian will be required to pick my child up from activity, or alternative transport arrangements will be made at my cost. | | |
| In the event of my child behaving irresponsibly and/or not complying with rules, I agree to immediately collect my child from the activity or alternative transport arrangements will be made at my cost. | | |
| I also agree to supply my child with all necessary medication and understand that staff cannot administer medication to my child. | | |
| I understand and accept that it is my responsibility to advise WDHS of any changes to the information supplied. | | |
| Parent/ guardian name  . | Parent/ guardian signature  . | Date  \_\_\_ /\_\_\_ /\_\_\_ |

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| **BOOKINGS** | | |
| **All bookings must be made through Western District Health Service**  Cash, cheque, credit or debit card are accepted. Cheques must be made payable to Western District Health Service. Bookings can only be made Monday to Friday 9.00am – 5.00pm.  Only cancellations made a minimum of five working days prior to activity will be eligible for a refund. | | |
| **In person**  Frances Hewett Community Centre  2 Roberts Street,  Hamilton VIC 3300 | **Via mail**  Western District Health Service  Holiday Program  Frances Hewett Community Centre  PO Box 283 Hamilton VIC 3300 | **Over the phone:** 03 5551 8450  **Fax:** 03 5572 5371  **Email:** [fhcc@wdhs.net](mailto:fhcc@wdhs.net) |

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| **Payment details** | | | | | | | | | | | | | | | | | | | | | |
| Payment method  Cash  Cheque  Visa  Mastercard | | | | | | | | | | | | | | | | | | | | | |
| Cardholder’s name  . | | | | | | | | | | | | | | | | | | Date  \_\_\_ /\_\_\_ /\_\_\_ | | | |
| Card number | | | | | | | | | | | | | | | | | | | | | |
| . | . | . | . | |  | . | . | . | | . |  | . | . | . | . |  | . | | . | . | . |
| Expiry date  \_\_\_ /\_\_\_ /\_\_\_ | | | | Amount  . | | | | | Cardholders signature  . | | | | | | | | | | | | |

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| --- | --- | --- |
| **Office Use Only** | | |
| Staff member  . | | Date  \_\_\_ /\_\_\_ /\_\_\_ |
| Receipt number  . | Payment form  Cash  Cheque  Visa  Mastercard Invoice | Amount received $ . |