

Active After-school Communities – Parent\Guardian Consent Form

School \ Out of School Hours Care Service (OSHCS) details:

School or OSHCS Name

Activity(s) being delivered

Term		Activities	
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Child/ren details: To be completed by Parent\Guardian. PLEASE USE CAPITALS

Please include all children who are participating in the Active After-school Communities Program this term.

Child 1	First name	Last name	Sex (circle one)
	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F

Date of birth	Is child of Aboriginal or Torres Strait Islander origin? (circle one)	School Year (eg Year 4)
<input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 100%; height: 20px;" type="text"/>

Child 2	First name	Last name	Sex (circle one)
	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F

Date of birth	Is child of Aboriginal or Torres Strait Islander origin? (circle one)	School Year (eg Year 4)
<input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 100%; height: 20px;" type="text"/>

Child 3	First name	Last name	Sex (circle one)
	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F

Date of birth	Is child of Aboriginal or Torres Strait Islander origin? (circle one)	School Year (eg Year 4)
<input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 100%; height: 20px;" type="text"/>

Parent\Guardian details: To be completed by Parent\Guardian. PLEASE USE CAPITALS

Parent\Guardian first name	Parent\Guardian last name	Relationship to the child/ren
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

Does your household speak any languages other than English at home? (circle one)	Yes	No	If yes, what other languages?	
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

Postal address

Suburb/town	Postcode	State/Territory
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

Home landline phone number	Work landline phone number (if applicable)
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

Mobile phone number (if applicable)

Please turn over