Sprouts Program

School Address: 301-319 BANK STREET, SOUTH MELBOURNE VIC3205
Email: seedsandsprouts@gsm.vic.edu.au

CHILD DETAILS

Surname:

First name/s:

Preferred first name:

Date of birth:

MEDICAL INFORMATION

Medical Condition:	Please specify any medical conditions the student suffers from eg. asthma, diabetes and/or any prescribed medications taken by the student. You need to provide an Action Plan and hand it in to the school office prior to the commencement of the first session.
Allergies:	Please list any known allergies the student has eg. allergy to nuts, penicillin, bee stings including specific details.

Has the child been diagnosed as being at risk of anaphylaxis?	Yes ☐ No ☐
If yes, does the student have an EpiPen?	Yes ☐ No ☐

ADDITIONAL NEEDS

Does your child have any additional needs? Please give details of how your child can be best supported and provide any relevant documentation.

Has your child ever seen a:

behavioural optometrist	☐	audiologist	☐ speech pathologist	☐
educational psychologist	☐	paediatrician	☐ occupational therapist	☐
psychologist	☐	other specialist	☐	

Is there anything else we should know about your child to ensure a smooth transition into our program? e.g. excessive fears, favourite activities

Guardian DETAILS (Emergency Contact)	
GUARDIAN	
Name	
Relationship	
Contact number:	

Emergency Medical Consent	I, …… A person with lawful authority of the child referred to in this enrolment form: • Declare that the information in this enrolment form is true and correct and undertake to immediately inform the children's service in the event of any change to this information; • Agree to collect or make arrangements for the collection of the child referred to in this enrolment form if s/he becomes unwell at the service; and, • Consent to the staff of the children's service seeking, or where appropriate, administering such emergency medical treatment as is reasonably necessary, which includes transport by ambulance if necessary, and that I will reimburse any necessary expenses incurred by the children's service.
Photographs	I acknowledge that my child may be photographed or filmed by staff and or Galilee students. I understand that such photographs/footage may be used in internal and external advertising such as internal communications, Galilee social media and the school website.
Session Preference	My preference is for: (Please circle). Tuesday Sessions: Wednesday Sessions No preference *I understand that all efforts will be made to allocate my child into my preferred session, however, this may not always be possible.
Cost	I acknowledge that there is a cost of $150 for my child to participate in the Sprouts Program. I agree to pay the $150 program cost if my child is accepted into the program. I understand the fee must be paid in full prior to the commencement of the program. I understand that once the fee is paid there is no refund should I decide my child will not participate in the program.
Acknowledgement	By signing and dating below, I am agreeing to the above: Emergency Medical Consent, Photographs, Session Preference and Cost. Signature …… Date……