

GOLD COAST POLICE CITIZENS' YOUTH CLUB



**Broadbeach PCYC School Age Care
Before and After School Care - Term 1 2010**



GUARDIAN SURNAME: FIRST NAME: FAMILY CRN:
 HOME PHONE: WORK MOBILE:
 EMAIL:

Please print the number corresponding to the child's name eg 1 against the days you wish to book the child in for this program.

CHILD 1	<input type="text"/>	CRN: <input type="text"/>	DOB: <input type="text"/>
CHILD 2	<input type="text"/>	CRN: <input type="text"/>	DOB: <input type="text"/>
CHILD 3	<input type="text"/>	CRN: <input type="text"/>	DOB: <input type="text"/>
CHILD 4	<input type="text"/>	CRN: <input type="text"/>	DOB: <input type="text"/>

PLEASE NOTE: If Children need to be transported by GCPCYC Vehicles - all have safety restraints except for our 22 seater Coaster bus

BEFORE SCHOOL CARE \$11 per session	AFTER SCHOOL CARE \$15 per session
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The children depart the Child Care room at 8:30 am, except for Prep who are accompanied to their classroom when bell rings

The children arrive at the Child Care room at 3:00pm. Prep children are collected from their class

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QPCYWA

Queensland Police Citizens Youth Welfare Association

Teaching Tolerance

Anti-Bulling Pledge

We the students of _____

Agree to join together to STOP bullying.

Name: _____

Date of Birth: _____

BY SIGNING THIS PLEDGE I AGREE TO:

- Treat others respectfully.
- Try to include those who are left out.
- Refuse to bully others
- Refuse to watch, laugh or join in when someone is being bullied
- Tell an adult
- Help those who are being bullied

Signed by _____

Date _____

Coordinator _____



QPCYWA

Queensland Police Citizens Youth Welfare Association

Food Allergy Card

To the Chef,

WARNING!

I am allergic to _____ . In order to avoid a life-threatening reaction, I must avoid foods that might contain

_____, including these ingredients.

Please ensure that my food does not contain any of these ingredients, and that any utensils and equipment used to prepare my meal, as well as prep surfaces are thoroughly cleaned prior to use.

Thank you for your cooperation.

Name _____

Date of Birth _____



1. Important Information

This form **MUST** be completed if your child requires medication whilst in attendance in the PCYC School Age Care Service. Please note all medication must be in the correct container and clearly labelled. Labelling must indicate child's name, required dosage and display a valid date. All medication must be handed to staff. Children cannot self medicate.

1. Child's Details

Family name (Please PRINT)

Given name(s)

Date of Birth

Day	Month	Year
/	/	

2. Medication Details

Please Note: All prescribed and Un-prescribed medication will need a *Pharmaceutical Label* with *Child's Name* clearly printed.

Is the medication prescribed (e.g. antibiotics, lotions) or un-prescribed (e.g. paracetamol, cough mixture)?

Prescribed ⇒ *This form expires after 5 days*

Un-prescribed ⇒ *This form expires after 1 day*

Name of Medication (as it appears on label)

Required Dosage

Date and Time medication to be given

2. Medication Details - Continued

Should medication be given:

Before food

With food

After food

Not applicable

Time last dose was administered

Reason for giving medication

Name of prescribing Doctor

Prescribing Doctor's telephone number

Special Instructions

3. Parent's Authorisation

I Parent/guardian

Of

give permission for the staff at PCYC to administer the above medication.

Signature

Date

PRINT name

Office Use:

Day No	Dosage	Date Given	Time Given	Staff 1 Full Name	Initial 1	Staff 2 Full Name	Initial 2
1	A						
	B						
<i>Un-prescribed medications need a new form to be completed</i>							
2	A						
	B						
3	A						
	B						
4	A						
	B						
5	A						
	B						