St Gerard's OSHC Carlingford
543 North Rocks Road, Carlingford NSW 2118
T: 0417 193 647
E: oshc.carlingford@catholiccaredbb.org.au
W: https://www.catholiccaredbb.org.au

CatholicCare
Diocese of Broken Bay

Expression of interest

Preferred days of attendance *(please select)*

Date of application: ----------

	Monday	Tuesday	Wednesday	Thursday	Friday
Before school care	☐	☐	☐	☐	☐
After school care	☐	☐	☐	☐	☐
Vacation Care	☐	☐	☐	☐	☐

☐ **Casual days only**

Child details	Child 1	Child 2	Child 3
First Name			
Last name			
D.O.B.			
Gender	☐ **Male** ☐ **Female**	☐ **Male** ☐ **Female**	☐ **Male** ☐ **Female**
School attending			
Class year			
Proposed start date			

Parent/Guardian 1			Parent/Guardian 2		
Full name:			**Full name:**		
DOB:			**DOB:**		
Relationship to child:			**Relationship to child:**		
Address:			**Address:**		
T:	**M:**	**W:**	**T:**	**M:**	**W:**
Email:			**Email:**		

Other relevant information
Reason for care:

Other relevant information

Does your child have an additional need or require support? ☐ No ☐ Yes *(Please provide details.)*

Does your child have any allergies? ☐ No ☐ Yes *(Please provide type of allergy and details.)*

Work / Training / Study status *(Please indicate which of the following applies to you and, if relevant to your partner.)*

Parent / Guardian / Carer

☐ Working full time ☐ Working part time ☐ Training / Studying

Partner

☐ Working full time ☐ Working part time ☐ Training / Studying

Access priority

Does your child or your family identify as Aboriginal or Torres Strait Islander? ☐ No ☐ Yes

Does your child or someone in your immediate family have a disability? ☐ No ☐ Yes

Does your child speak primarily another language other than English? ☐ No ☐ Yes, _____
(Provide Language)

Does your family hold a low-income Health Care Card? ☐ No ☐ Yes

Are you a sole parent? ☐ No ☐ Yes