**ADMISSION INFORMATION**

| | | | |
|---|---|---|---|
| Operation Name: | | Director's Name: | |
| Child's Name: | | Date of Birth: | Child's Home Telephone No.: |
| Child's Home Address: | | | |
| Date of Admission: | Date of Withdrawal: | Hours and days child will be in care: | |
| Parent's or Guardian's Name: | | Address (if different from child's): | |
| Telephone numbers where parents/ guardian may be reached | Mother's Ph.#: | Father's Ph.#: | Guardian's Ph.#: |
| Name, address and phone number of person to call in case of an emergency if parents/guardian cannot be reached: | | | Relationship: |

I hereby authorize the childcare operation to allow my child to leave the childcare operation ONLY with the following persons. Please list name & telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.

CHECK ALL THAT APPLY:

1. ☐ TRANSPORTATION: I hereby give consent for my child to be transported and supervised by the operation's employees: ☐ Yes ☐ No
   If yes, check all that apply: ☐ emergency care ☐ on field trips ☐ to/from home ☐ to/from school
2. ☐ FIELD TRIPS: I hereby give consent for my child to participate in Field Trips: ☐ Yes ☐ No
   Parent's Comments:
3. ☐ WATER ACTIVITIES: I hereby give consent for my child to participate in Water Activities: ☐ Yes ☐ No If yes, check all that apply:
   ☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ water table play
4. ☐ RECEIPT OF WRITTEN OPERATIONAL POLICIES: I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

| | | |
|---|---|---|
| Name of Physician: | Address: | Ph.#: |
| Name of Emergency Medical Care Facility: | Address: | Ph.#: |

I give consent for the facility to secure any and all necessary emergency medical care for my child.

_____
Signature - Parent or Legal Guardian Date

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of:

_____

_____

SCHOOL AGE CHILDREN (CHECK ALL THAT APPLY):

☐ My child attends the following school:

_____
Name of School and Address Phone Number

☐ His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

☐ My child has permission to:

☐ ride a bus ☐ walk to and from school ☐ be released to the care of his/her sibling(s) under 18 years old

Name of sibling(s):

_____
Signature - Parent or Legal Guardian Date

**ADMISSION INFORMATION**

| HEALTH REQUIREMENTS | | | | | |
|---|---|---|---|---|---|
| Name of Child: | | | | Date of Birth: | |
| Immunizations | Date / dose 1 | Date / dose 2 | Date / dose 3 | Date / dose 4 | Date / booster |
| Hepatitis B | | | | | |
| DTP / DTaP / DT | | | | | |
| Hib | | | | | |
| Polio IPV or OPV | | | | | |
| Measles | | | | | |
| Mumps | | | | | |
| Rubella | | | | | |
| Varicella (see below) | | | | | |
| Pneumococcal Conjugate Vaccine | | | | | |
| Hepatitis A | | | | | |
| TB Test (if required) | ☐ Positive | ☐ Negative | Date: | | |

Signature or stamp of a physician or public health personnel verifying immunization information above.

Signature _____ Date _____

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) _____ and does not need varicella vaccine.

Parent's signature _____ Date _____

☐ I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

For additional information regarding immunizations contact the Department of State Health Services at http://www.dshs.state.tx.us/immunize/school_info.htm

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

PLEASE CHECK ONLY ONE OPTION:

☐ 1. Health-Care Professional's Statement: I have examined the above named child within the past year and find that he / she is physically able to take part in the day care program.

Health Care Professional's Signature _____ Date _____

☐ 2. A signed and dated copy of a health care professional's statement is attached.

☐ 3. Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

☐ 4. My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

Name and address of health care professional:

Signature - Parent or Legal Guardian _____ Date _____

| VISION | R 20/ _____ | L 20/ _____ | ☐ Pass ☐ Fail |
|---|---|---|---|
| Signature: | | Date: | |

| HEARING | 1000 Hz | 2000 Hz | 4000 Hz | ☐ Pass ☐ Fail |
|---|---|---|---|---|
| R | | | | |
| L | | | | |
| Signature: | | Date: | | |

Signature - Parent or Legal Guardian _____ Date _____