Texas Dept of Family and Protective Services

ADMISSION INFORMATION

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Operation Name		Director's Name						
Child's Full Name		Child's Date of Birth	Child's Home Telephone No.					
Sima si aminamis		Offind a Batta of Birth	Office Policy Total					
Child's Home Address								
Date of Admission	Date of Withdrawal							
Parent's or Guardian's Name		Address (if different from child's add	ress)					
			•					
List telephone numbers below where p								
Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.	Cell Phone No					
Give the name, address and phone nu	mber of person to call in case of an er	mergency if parents / guardian cannot b	pe reached: Relationship					
I hereby authorize the childcare operat telephone number for each. Children v								
telepriorie number for each. Children v	will only be released to a parent of a p	erson designated by the parent/guardia	an after verification of ID.					
	<u> </u>							
	nereby give do not give	- consent for my child to be trans	sported and supervised by the					
1. TRANSPORTATION: Walk home	for emergency care on fie	operation's employees: eld trips	me to and from school					
2. FIELD TRIPS:	nereby give do not give	- my consent for my child to part	cipate in Field Trips:					
Parent's Comments:								
3. WATER ACTIVITIES:	nereby 🗌 give 🔲 do not give 🔲 sprinkler play 🔲 splashi	 my consent for my child to part ng/wading pools swimming pools 						
4. RECEIPT OF WRITTEN OPER		ng, naamg poole 🗀 ommining p	inator table play					
I acknowledge receipt of the f	acility's operational policies includi	ng those for discipline and guidance	9.					
5. I UNDERSTAND THAT THE FOLL		_	_					
☐ None ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack								
6. MY CHILD IS NORMALLY IN CARE		TIMES:						
☐ Mondays from:	to:							
☐ Tuesdays from:	to:							
☐ Wednesdays from:	to:							
☐ Thursdays from:	to:							
☐ Fridays from:	to:							
☐ Saturdays from:	to:							
☐ Sundays from:	to:							
AUTHORIZATION FOR EMER	GENCY MEDICAL ATTENTION	ON:						
In the event I cannot be reached to	make arrangements for emergency	medical care, I authorize the perso	n in charge to take my child to:					
Name of Physician:	Address:		Ph.#:					
Name of Emergency Medical Care F	acility: Address:		Ph.#:					
I give consent for the facility to secu necessary emergency medical care								
		Signature - Parent or Legal	Guardian					
List any special problems that your of during the past 12 months, any med aware of:								
Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800)-514-0383 (TTY).								
Signatur	e – Parent or Legal Guardian		Date					

ADMISSION INFORMATION

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scн	OOL AGE CHILDREN: My child attends the followin	g school:							
-		School Ph.#							
	CHECK ALL THAT APPLY:								
	His / her immunization recor required immunizations and/ Vision and Hearing screenin	or tuberculosis test are	current.	walk to or from school or home, be released to the care of his/her sibling(s) under 18 years old.					
	Name of sibling(s):		'						
IMM	UNIZATION RECORD:								
	have provided the childcare	operation with a copy of	of my child's n	nost curre	ent immunization rec	ord.			
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 able to take part in the day care program.									
		Health Care Profession	al's Signature			Date			
Health Care Professional's Signature Date 2.									
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.									
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 Le	egal Guardian			Date			
	VISION	R 20/		L 20/		☐ PASS ☐ FAIL			
SIGNATURE				DATE _					
	HEARING	1000 Hz	2000 H	łz	4000 Hz				
	R L					PASS _ FAIL			
SIGNATURE			DATE						
	Signat	ure – Parent or Legal C	Suardian			Date			

Texas Dept of Family and Protective Services

ADMISSION INFORMATION

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HEALTH REQUIREMENTS											
Name of Child: Date of Birth:											
Age ► Vaccine ▼	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	2-3 Yrs	4-6 Yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus influenzae type b											
Pneumococccal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											
TB TEST (if required)	Positive Date:										
Signature or stamp of a physician or public health personnel verifying immunization information above.											
					Sign	ature		 -		Date	
Varicella (chickenpox) vac	cine is not r	equired if y	our child ha	as had chick	enpox dise	ase. If your	child has h	ad chicken	oox, please	complete th	ie
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 www.dshs.state.tx.us/immunize/public.shtm											