ADMISSION INFORMATION

Operation Name		Director's Name	
LITTLE ANGELS PLAYHOUSE		Milagros García	
Child's Full Name		Child's Date of Birth	Child's Home Telephone No.
Child's Home Address			
Date of Admission	Date of Withdrawal		
Parent's or Guardian's Name		Address (if different from child's address)	

List telephone numbers below where parents/guardian may be reached while child will be in care:

Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.	Cell Phone No

Give the 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 ☐ do not give – consent for my child to be transported and supervised by the operation's employees:

Walk home ☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. ☐ FIELD TRIPS: I hereby ☐ give ☐ do not give – my consent for my child to participate in Field Trips:

Parent's Comments:

3. ☐ WATER ACTIVITIES: I hereby ☐ give ☐ do not give – my consent for my child to participate in Water Activities:

☐ 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.

5. I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:

☐ **None** ☐ **Breakfast** ☐ **AM Snack** ☐ **Lunch** ☐ **PM Snack** ☐ **Supper** ☐ **Evening Snack**

6. MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:

☐ Mondays	from:	to:
☐ Tuesdays	from:	to:
☐ Wednesdays	from:	to:
☐ Thursdays	from:	to:
☐ Fridays	from:	to:
☐ Saturdays	from:	to:
☐ Sundays	from:	to:

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

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:

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).

_____ _____
Signature – Parent or Legal Guardian Date

ADMISSION INFORMATION

SCHOOL AGE CHILDREN:

☐ My child attends the following school:

_____ _____
Name of School and Address School Ph.#

CHECK ALL THAT APPLY:

☐ 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.

Name of sibling(s):

My child has permission to:
☐ walk to or from school or home,
☐ ride a bus, and/or
☐ be released to the care of his/her sibling(s) under 18 years old.

IMMUNIZATION RECORD:

☐ I have provided the childcare operation with a copy of my child's most current immunization record.

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 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	
R				☐ PASS ☐ FAIL
L				
SIGNATURE _____		DATE _____		

_____ _____
Signature – Parent or Legal Guardian Date

ADMISSION INFORMATION

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	☐ 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
www.dshs.state.tx.us/immunize/public.shtm

Signature – Parent or Legal Guardian — Date