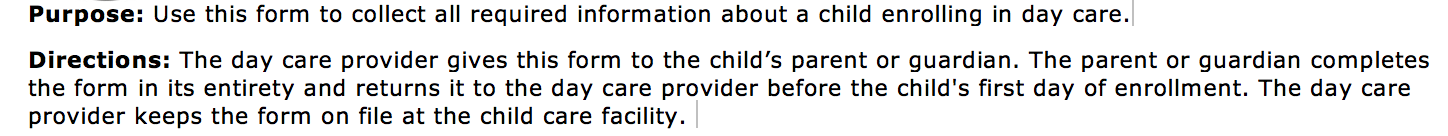
Form J-800-2935

Revised June 2017







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| **GENERAL INFORMATION** | | | | | | |
| Operation’s Name:  **Excelencia – Creative Bilingual Preschool** | | | Director’s Name: | | | |
| Child’s Full Name: | | | Child’s Date of Birth: | Child Lives With: (circle) Mom Dad  Both Parents Guardian | | |
| Child’s Home Address: | | | | | | |
| Date of Admission: | | | Date of Withdrawal: | | | |
| Name of Parent or Guardian: | | | Address: (if different from child’s) | | | |
| Relationship to child: | Email: | | | Mobile Phone Number: | | Other Phone Number: |
| Name of Parent or Guardian: | | | Address: (if different from child’s) | | | |
| Relationship to child: | Email: | | | Mobile Phone Number: | | Other Phone Number: |
| Any Child Custody Issues: Yes No | | | If Yes, are custody documents on file: Yes No | | | |
| Emergency Contact in the event a parent or guardian cannot be reached:  Name: Address: Phone: Relationship: | | | | | | |
| Other than the parents/guardians, only the following persons are authorized to pick up my child.  Verification of ID will be required for any parent/guardian or authorized person not recognized by staff. | | | | | | |
| Name and Phone Number: | | Name and Phone Number: | | | Name and Phone Number: | |

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| **CONSENT INFORMATION** |
| **CHECK ALL THAT APPLY** |
| 1. **TRANSPORTATION**   I give consent for my child to be transported and supervised by Excelencia staff:  for emergency care  on field trips  to and from home  to and from school |
| 1. **FIELD TRIPS**   I give consent for my child to participate in field trips.  I **do not** give consent for my child to participate in field trips.  **Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| 1. **WATER ACTIVITIES**   I give consent for my child to participate in the following water activities:  Water table play  Splash pad  Sprinkler play  small wading pool |

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| **CONSENT INFORMATION** | | | |
| **CHECK ALL THAT APPLY:** | | | |
| 1. **RECEIPT OF WRITTEN OPERATIONAL POLICIES** | | | |
| I acknowledge receipt of Excelencia Preschool’s operational policies (Parental Handbook) including the following: | | | |
| Discipline and guidance | | Procedures for release of children | |
| Suspension and expulsion | | Illness and exclusion criteria | |
| Emergency plans | | Procedures for dispensing medications | |
| Procedures for conducting health checks | | Immunization requirements | |
| Safe sleep | | Meal and food service practices | |
| Procedures for parents to discuss concerns with the director | | Procedures to visit Excelencia Preschool without securing prior approval | |
| Procedures for parents to participate in Excelencia activities | | Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website | |
| 1. **MEALS**   I understand that only the following meals will be served to my child while in care:  Morning snack, Lunch (parent provided), Afternoon snack, Pizza on Fridays, special occasion snacks provided by parents for birthdays, etc. | | | |
| 1. **DAYS AND TIMES IN CARE**   My child will normally be in care on the following days and times: | | | |
| **Day of the Week** | **AM** | | **PM** |
| Monday |  | |  |
| Tuesday |  | |  |
| Wednesday |  | |  |
| Thursday |  | |  |
| Friday |  | |  |
| Saturday | Closed | | Closed |
| Sunday | Closed | | Closed |

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| **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: | | Phone: |
| Name of Emergency Care Facility: | Address: | | Phone: |
| I give consent for the facility to secure any and all necessary emergency medical care for my child. | | Signature – Parent or legal guardian Date: | |

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| **CHILD’S ADDITIONAL INFORMATION SECTION** | |
| List any special needs that your child may have, such as environmental allergies, food intolerances or allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medications prescribed for long term continuous use, and any other information which caregivers should be aware of:  Does your child have any diagnosed food allergies? Yes  No  If yes, plan submitted on (date): | |
| Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that Excelencia Preschool may be practicing discrimination in violation of Title III, you may call the ADA Information Line at 1-800-514-0301 (voice) or 1-800-514-0383 (TTY). | |
| Signature – Parent or Legal Guardian: | Date Signed: |

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| **SCHOOL AGE CHILDREN**  (Only complete if your child will attend a K-12 school in addition to Excelencia Preschool) | |
| My child attends the following school: | |
| Name of School: | School Phone Number: |
| My child has permission to (check all that apply):  walk alone to or from school or home  ride a bus  be released to the care of a sibling under 18. | |
| Authorized pick up/drop off locations other than the child’s home address: | |

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| **ADMISSION REQUIREMENT** | |
| Name and Address of Health Care Professional (pediatrician): | |
| If your child does not attend pre-kindergarten or school away from Excelencia Preschool, one of the following must be presented when your child is admitted to Excelencia Preschool or within one week of admission.  **Please review all options below and then check only one option:** | |
| 1. HEALTH CARE PROFESSIONALS STATEMENT: I have examined the above named child within the past year and find that he or she is able to take part in a daycare program. | |
| Signature of Health Care Professional: | Date Signed: |
| 1. A signed and dated copy of a health care professional’s statement is attached. | |
| 1. Medical diagnosis and treatment conflict with the tenants 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. | |
| 1. My child has been examined within the past year by the health care professional named above, and is able to participate in a daycare program. Within 12 months of admission, I will provide a written signed health care professional’s statement to Excelencia Preschool. | |
| Signature – Parent or Legal Guardian | Date Signed: |

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| **REQUIREMENTS FOR EXCLUSION** |
| I have attached a signed and dated affidavit stating that I decline immunizations for reasons of conscious, including religious belief, on the form described by section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.  I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of. |

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| **VARICELLA (CHICKEN POX) EXCLUSION** | |
| The varicella vaccine is not required if your child has had the chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about \_\_\_\_\_\_\_\_  and does not need the varicella vaccine. | |
| Parent/Guardian’s Signature: | Date Signed: |

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| **ADDITIONAL INFORMATION REGARDING IMMUNIZATIONS** |
| For additional information regarding immunizations, visit the Texas Dept. of State Health Services’ website at  www.dshs.state.tx.us/immunizize/public.shtm. |

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| **GANG FREE ZONE** |
| Under the Texas Penal Code, any are within 1000 feet of a child care center is a gang free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties. |

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| **PRIVACY STATEMENT** |
| DFPS values your privacy. For more information, read our Privacy and Security Policy online at  www.dshs.state.tx.us/policies/privacy.asp. |

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| **SIGNATURES** | |
| Parent/Guardian’s Signature: | Date Signed: |
| Excelencia Preschool Representative Signature: | Date Signed: |

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| **VACCINE INFORMATION**  **(This sheet is not required if the child’s physician has provided this information in a**  **document containing the child’s immunization records)** | | | |
| The following vaccines require multiple doses over time. Please provide the date for each dose the child received. | | | |
| **Vaccine** | **Dose** | **Vaccine Schedule** | **Dates received** |
| DTaP (Diphtheria, Tetanus, and Pertussis) | 1 | 2 months |  |
| 2 | 4 months |  |
| 3 | 6 months |  |
| 4 | 15-18 months |  |
| 5 | 4 – 6 years |  |
| Hepatitis B | 1 | Birth |  |
| 2 | 1 – 2 months |  |
| 3 | 6–18 months |  |
| Hib (Haemophilus Influenza Type B) | 1 | 2 months |  |
| 2 | 4 months |  |
| 3 | 6 months |  |
| 4 | 12-15 months |  |
| PNV 13 (Pneumococcal Virus) | 1 | 2 months |  |
| 2 | 4 months |  |
| 3 | 6 months |  |
| 4 | 12-15 months |  |
| IPV (Inactivated Polio Virus) | 1 | 2 months |  |
| 2 | 4 months |  |
| 3 | 6–18 months |  |
| 4 | 4 – 6 years |  |
| MMR (Measles, Mumps, Rubella) | 1 | 12-15 months |  |
| 2 | 4 – 6 years |  |
| Varicella | 1 | 12-15 months |  |
| 2 | 4 – 6 years |  |
| Hepatitis A | 1 | 12-23 months |  |
| 2 | 18-43 months |  |

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| **VACCINE VERIFICATION** | |
| Signature or stamp of physician or public health personnel verifying the immunization information above. | |
| Signature: | Date: |

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| **VISION EXAM RESULTS**  (Required within 120 days of 4th birthday) | | | |
| R 20 / \_\_\_\_\_\_\_\_\_ | L 20 / \_\_\_\_\_\_\_\_\_\_ | | Pass  Fail |
| Signature: | | Date: | |

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| **HEARING EXAM RESULTS**  (Required within 120 days of 4th birthday) | | | | | |
| **Ear** | **1000 Hz** | **2000 Hz** | | **4000 Hz** | **Pass or Fail** |
| **Right** |  |  | |  |  |
| **Left** |  |  | |  |  |
| Signature: | | | Date: | | |