ENROLLMENT FORM

CHILD'S NAME			BIRTHDATE
CHILD'S ADDRESS			HOME PHONE
MOTHER'S NAME			HOME PHONE
MOTHER'S ADDRESS			ZIP
EMPLOYED BY			WORK PHONE
ADDRESS			ZIP
DRIVER'S LICENSE #	BIRTH DATE / /	SOCIAL SECURITY # — —	
FATHER'S NAME			HOME PHONE
FATHER'S ADDRESS			ZIP
EMPLOYED BY			WORK PHONE
ADDRESS			ZIP
DRIVER'S LICENSE #	BIRTH DATE / /	SOCIAL SECURITY # — —	

PERSON TO CALL IN CASE OF EMERGENCY IF PARENTS/GUARDIAN CANNOT BE REACHED:	TELEPHONE NO.	RELATIONSHIP
I HEREBY AUTHORIZE THE DAY CARE FACILITY TO ALLOW MY CHILD TO LEAVE THE DAY CARE FACILITY ONLY WITH THE FOLLOWING PERSONS:		TELEPHONE NO.

DATE OF ADMISSION	HOURS AND DAYS CHILD WILL BE IN CARE

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

____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:
In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:

NAME OF LICENSED PHYSICIAN	ADDRESS	TELEPHONE NO.
OR TO (NAME OF HOSPITAL OR CLINIC)	ADDRESS	TELEPHONE NO.

I give my consent for necessary emergency treatment when my child is in the care of this physician and/or hospital/clinic.

Signature - Parent or Legal Guardian ______________ Date ______________

1. **TRANSPORTATION:** I hereby ❑ give ❑ do not give my consent for my child to be transported and supervised by facility's staff:
   ❑ On Field Trips ❑ To and From Home ❑ To and From School

2. **WATER ACTIVITIES:** I hereby ❑ give ❑ do not give my consent for my child to participate in water activities:
   ❑ Splashing Pools ❑ Wading Pools ❑ Swimming Pools ❑ Other bodies of water provided by the facility

Parent's Comment: ____

3. **SCHOOL-AGE CHILDREN:** My child attends:

NAME OF SCHOOL	SCHOOL'S TELEPHONE NO.

My child's immunization record is on file at the school and all immunizations and tuberculosis test results are current.

Signature - Parent or Legal Guardian ______________ Date ______________

PARENT'S ACKNOWLEDGMENT:
This is to acknowledge that ______________ (Name of Facility Staff) has provided me with The Operational Policy of the Daycare, and the "The Parent Handbook" and has discussed its contents with me.

Signature - Parent or Legal Guardian ______________ Date ______________

HEALTH REQUIREMENTS

CHILD'S NAME	BIRTHDATE

IMMUNIZATIONS	DATE 1st Dose	DATE 2nd Dose	DATE 3rd Dose	DATE 1st Booster	DATE 2nd Booster
DPT/Td					
Polio					
Measles: Vaccine - Rubeola					
Mumps: Vaccine					
Rubella: Vaccine					

NOTE: You may submit a machine copy of an immunization record signed or stamped by a physician or health care personnel.

PHYSICIAN'S VERIFICATION MUST BE SUBMITTED	
Measles: Date of Illness	**Mumps**: Date of Illness

Tuberculosis Test: To be completed if recommended for the area by the Texas Department of Health. (Day care facility staff will inform parents of these requirements.) ....

Results ❑ Positive ❑ Negative	Date

Signature (or stamp) - Physician or Health Personnel　　Date　　Signature - Staff Making Handwritten Copy of Record　　Date

ADMISSION REQUIREMENT: One of the following must be presented when your preschool-age child is admitted to the day care facility or within one week of admission. Check to indicate the option you select:

❑ **Doctor'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. ....

Physician's Signature　　Date

❑ A copy of the medical screening form of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program **IF** no referral for further diagnosis and treatment is indicated.

❑ A form or written statement from a health service or clinic.

If you do not have any of the above:

❑ **Parent's Statement:** My child has been examined within the past year by a licensed physician and is able to participate in the day care program:

NAME AND ADDRESS OF PHYSICIAN **OR** ADDRESS OF EPSDT SCREENING SITE

❑ Within the next 12 months I will obtain a physician's statement, a copy of the medical screening form from the EPSDT Program, or a form or statement from a health service or clinic and will submit it to the day care facility.

OR

❑ My child has an appointment for a physical examination:

DATE	NAME AND ADDRESS OF PHYSICIAN **OR** ADDRESS OF EPSDT SCREENING SITE

I will submit the physician's statment, EPSDT form, or health service or clinic form to the day care facility following the examination.

Signature - Parent or Legal Guardian　　Date

NOTE: If medical diagnosis and treatment and/or immunizations and TB testing conflict with your religious beliefs, you must sign an affidavit to that effect and attach it to this form.

If immunization and/or TB testing would be injurious to your child or family, you must obtain a certificate (signed by a physician) to that effect and attach it to this form.