THREE R'S SCHOOL ENROLLMENT FORM

CHILD'S NAME			BIRTHDATE
CHILD'S HOME ADDRESS			HOME PHONE
MOTHER'S NAME			CELL PHONE & PROVIDER (FOR DAYCARE MESSAGES)
MOTHER'S HOME ADDRESS			ZIP
EMPLOYED BY			WORK PHONE
ADDRESS			ZIP
DRIVER'S LICENSE #	DATE OF BIRTH	SOCIAL SECURITY # ___ ___	EMAIL - MOTHER
FATHER'S NAME			CELL PHONE & PROVIDER (FOR DAYCARE MESSAGES)
FATHER'S HOME ADDRESS			ZIP
EMPLOYED BY			WORK PHONE
ADDRESS			ZIP
DRIVER'S LICENSE #	DATE OF BIRH	SOCIAL SECURITY # ___ ___	EMAIL- FATHER

PERSON TO CALL IN CASE OF EMERGENCY IF PARENTS/GUARDIAN CANNOT BE REACHED:	TELEPHONE NO.	RELATIONSHIP

I HEREBY AUTHORIZE THE DAY CARE FACILITY TO RELEASE MY CHILD TO THE FOLLOWING PERSONS. INCLUDE NAMES AND PHONE NUMBERS:

DATE OF ADMISSION/ WITHDRAW	HOURS AND DAYS CHILD WILL BE IN CARE	MEALS TO BE SERVED TO MY CHILD __ALL MEALS SERVED __BREAKFAST __AM SNACK __LUNCH __PM SNACK __DINNER

List any special problems that your child may have, such as allergies, food intolerances, existing illness, previous serious illness, injuries during the past 12 months, limitations or restrictions on child's activities, any medication prescribed for long-term continuous use, reasonable accommodations or modifications, adaptive equipment, symptoms or indications of complications, 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 _____

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 ☐ For emergency care

WATER ACTIVITES: I hereby ☐ give ☐ do not give my consent for my child to participate in the following water activities:

☐ water table play ☐ sprinkler play ☐ aquatic playgrounds

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

_____

Signature and Date

PARENT'S ACKNOWLEDGMENT: I acknowledge receipt of THREE R'S SCHOOL " Parent Handbook".
This includes the Operational Policies. The following topics were discussed: (Check all that apply

☐Tuition Policy ☐ Payment Policy ☐ Volunteer ☐Drop off/pick up ☐Illness and Medication ☐ Emergency Plan ☐ Parent involvement
☐Parent Conference ☐Meals ☐ Screen Time Policy ☐ Immunizations ☐Inclement Weather ☐ Daily Schedules ☐Absences
☐Contact Information ☐TSR certification ☐Accommodations for Families ☐Challenging Behavior

Signature - Parent or Legal Guardian _____ Date _____

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 _____

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_____ and does not need varicella vaccine.

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 statement, 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.