TEXAS Health and Human Services

Excelencia CREATIVE BILINGUAL PRESCHOOL

Admission Information

General Information

Operation's Name: **Excelencia – Creative Bilingual Preschool**		Director's Name:	
Child's Full Name:	Child's Date of Birth	Child Lives With: ○ Both Parents ○ Mom ○ Dad ○ Guardian	
Child's Home Address:		Date of Admission	Date of Withdrawal
Name of Parent or Guardian Completing Form		Address: (if different from the 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	

Give the below information of the responsible individual to call in case of an emergency if parents/guardian cannot be reached:

Name: _____ Address: _____ Phone: _____ Relationship: _____

I authorize the Excelencia Preschool **to release** my child to leave the preschool **ONLY** with the following persons. Please list the name and telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID.

Name	Phone Number
Name	Phone Number
Name	Phone Number

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/or from home ☐ to and/or from school

2. **Field Trips** (are not offered)

~~○ I give consent for my child to participate in field trips.~~

~~○ I do not give consent for my child to participate in field trips.~~

3. **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

4. Receipt of Written Operational Policies (Check All that Apply)

I acknowledge receipt of Excelencia Preschool's operational policies (Parental Handbook) including those for:

- ☐ Discipline and guidance
- ☐ Suspension and expulsion
- ☐ Emergency plans
- ☐ Procedures for conducting health checks
- ☐ Safe sleep
- ☐ Procedures for parents to discuss concerns with the director
- ☐ Procedures for parents to participate in Excelencia activities
- ☐ Procedures for release of children
- ☐ Illness and exclusion criteria
- ☐ Procedures for dispensing medications
- ☐ Immunization requirements
- ☐ Meal and food service practices
- ☐ Procedures to visit Excelencia Preschool without securing prior approval
- ☐ Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and CCL website

5. Meals

I understand that 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.

6. 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

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

Child's Additional Information Section

List any special needs that your child may have, such as environmental allergies, food intolerances or, 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 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:

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:	

Admission Requirement

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.

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:

2. ○ A signed and dated copy of a health care professional's statement is attached.
3. ○ 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.
4. ○ 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.

Name	Address of Health Care Professional (pediatrician)
_____ Signature – Parent or Legal Guardian	_____ Date Signed

Requirements for Exclusion

○ I have attached a signed and dated affidavit stating that I decline immunizations for reasons of conscience, 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.

Varicella (Chicken Pox)

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 (date) _____
and does not need the varicella vaccine.

_____ _____
Signature Date Signed

Additional Information Regarding Vaccines

For additional information regarding immunizations, visit the Texas Dept. of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm.

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.

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.

Signatures

_____ _____
Child's Parent or Legal Guardian Date Signed:

_____ _____
Excelencia Preschool Designee Date Signed:

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	

Physician or Public Health Personnel Verification

Signature or stamp of physician or public health personnel verifying the immunization information above.

_____ _____

Signature Date Signed

Vision Exam Results

(Required within 120 days of 4th birthday)

Right Eye 20 Left Eye 20 / ○ Pass ○ Fail

_____ _____

Signature Date Signed

Hearing Exam Results

(Required within 120 days of 4th birthday)

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				○ Pass ○ Fail
Left				○ Pass ○ Fail

_____ _____

Signature Date Signed