Texas Dept of Family and Protective Services

ADMISSION INFORMATION

Form 2935 March 2008 / Pg 1 of 2

Operation Name All Faiths Day	School	Director's Name						
Child's Name	Date of Birth	Child's I	Child's Home Telephone No					
child's Home Address								
ate of Admission	Date of Withdray	wal	Hours and days child will b	e in care				
arent's or Guardian's Name	1		Address (if different from c	hild's address)				
			Address (ii dillerent from G	Address (if different from child's address)				
ist telephone numbers where arents/guardian may be reached hile child will be in care:		Telephone No			Guardian's Telephone I			
live the name, address and phone nu	mber of person to	call in case of a	in emergency if parents / guardian	cannot be reached	: Relationsh			
hereby authorize the childcare operati elephone number for each. Children v	tion to allow my chil will only be released	ld to leave the o	childcare operation ONLY with the raperson designated by the parer	following persons. t/guardian after ver	Please list name & rification of ID.			
E	hereby give	operation's						
FIELD TRIPS: Parent's Comments:	I hereby 🗌 giv	re [do not give - my consent for	my child to partici	pate in Field Trips			
	I hereby giv	e de	o not give - my consent for my	child to participate	e in Water Activitie			
RECEIPT OF WRITTEN OPER I acknowledge receipt of the fa	sprinkler particular sprinkler	es: <u>Can be</u>	shing/wading pools swime swime found & www.allfa luding those for discipline and g	ithsdayscho uidance.	ol.com			
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RECEIPT OF WRITTEN OPER. I acknowledge receipt of the factor of the factor of the factor of the event I cannot be reached to not ame of Physician: I ame of Emergency Medical Care Factor of the facility to secur occurrences and event I cannot be reached to not one of the facility to secur occurrences. I ame of Emergency Medical Care Factor of the facility to secur occurrences and the facility to secur occurrences. I amy special problems that you obspitalizations during the past 1 on the caregiver's should be award of the facility of the facility to secur occurrences. I acknowledge receipt of the facility of the facility of the facility of the facility to secur occurrences.	sprinkler g ATIONAL POLICIE acility's operation GENCY MEDIO make arrangemen acility: re any and all for my child. ur child may have 2 months, any may re of: accommodation in g discrimination in	ES: An beal policies included and policies and	Signature - Parent or allergies, existing illness, pre rescribed for long-term continumericans with Disabilities Act (Title III, you may call the ADA I	thsdayschouldance. a person in charge Pl Legal Guardian vious serious illinuous use, and a	ness, injuries an			

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Form 2935 September 2007 / Pg 2 of 2

Age Notarion Birth 1 mos 2 mos 4 mos 6 mos 12 mos 15 mos 18 mos 19-23 2-3 Yrs 4-6 Y Hepatitis B	Name of Child: Date of Birth:											
Rotavirus		Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos		2-3 Yrs	4-6 Yrs
Diphtheria, Tetanus, Pertussis	Hepatitis B											
Pertussis	Rotavirus											
Influenza												
Inactivated Politovirus	influenzae type b											
Measles, Mumps, Rubella Varicella Hepatitis A Meiningococcal TB TEST (if required)	The state of the s										10	
Measing coccal Hepatitis A Meningcoccal Positive Negative Date:												
Rubella	THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, T											
Hepatitis A												
Meningococcal	Varicella							-/		War Comment		
Signature or stamp of a physician or public health personnel verifying immunization information above. Signature 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) Parent's signature Date 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 http://www.dshs.state.tx.us/immunize/school_info.htm 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 Parent's signature Parent or Legal Guardian Date VISION R 20/ L 20/ PASS FAIL SIGNATURE DATE HEARING 1000 Hz 2000 Hz 4000 Hz PASS FAIL	Hepatitis A									3. A. V		
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Signature or stamp of a physician or public health personnel verifying immunization information above. Signature Signature Date	TB TEST (if required)	Posi	tive	□ N	egative			Da	ate:			7.5
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Statement: My child had varicella disease (chickenpox) on or about (date) and does not need varicella vaccine.	Signature Date											
Parent's signature Date	statement: My child had y	cine is not i	required if you	our child ha	s had chick	enpox disea	ise. If your	child has h				
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