

## **Admission Information**

Use this form to collect all required information about a child enrolling in day care.

**Directions**: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

radiity.					
	Ger	neral Information			
Operation's Name:		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:	Admission: Date of Withdrawal:		
Name of Parent or Guardian Cor	npleting Form:	Address of Parent or G	Guardian <i>(if d</i>	ifferent from the child's):	
List phone numbers below where	parents or guardian may be re	ached while child is in care	).		
Parent 1 Phone No.: Parent 2 Phone No.:		Guardian's Phone No.:		Custody Documents on File?  Yes No	
In case of an emergency, call:					
Name of Emergency Contact:		Relationship:		Area Code and Phone No.:	
Address:					
				following persons. Please list nam nated by the parent or guardian aft	
Name:	Area Code and Phone No.:		a Code and Phone No.:		
Name:	Area Code and Phone No.:		a Code and Phone No.:		
Name:	Area Code and Phone No.:		a Code and Phone No.:		
	Cor	nsent Information			
1. Transportation:					
I give consent for my child to be t	transported and supervised by t	the operation's employees	(Check all th	at apply).	
for emergency care on field trips to and from home to and from school					
2. Field Trips:					
◯ I give consent for my child to p	participate in field trips. O I do	o not give consent for my c	hild to partici	ipate in field trips.	
Comments.					

3. Water Activities:						
I give consent for	my child to particip	ate in the following w	vater a	activities (Check all that apply).		
☐ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds						
Is your child able to swim without assistance?			Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming?			
				○ Yes ○ No		
Do you want your c swimming pool?	hild to wear a life jack	et while in or near a				
◯ Yes ◯ No						
4. Receipt of Written	4. Receipt of Written Operational Policies:					
I acknowledge receipt	of the facility's operati	onal policies, including	those	for (Check all that apply).		
Discipline and guid	ance		□ P	rocedures for release of children		
Suspension and ex	pulsion			ness and exclusion criteria		
Emergency plans			P	rocedures for dispensing medications		
Procedures for con	ducting health checks	•	Ir	nmunization requirements for children		
Safe sleep			N	leals and food service practices		
	ents to discuss conce		□ P	Procedures to visit the center without securing prior approval		
Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions		□ P	rocedures for supporting inclusive services			
☐ Procedures for parents to participate in operation activities		Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline, and CCR website				
5. Meals:						
I understand that the f	ollowing meals will be	served to my child wh	ile in c	are (Check all that apply):		
☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack						
6. Days and Times in Care:						
My child is normally in	care on the following	days and times:	_			
Day of the Week	A.M.	P.M.				
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
7. Receipt of Parent's	s Rights:					
I acknowledge I have	received a written cop	y of my rights as a par	ent or	guardian of a child enrolled at this facility.		
	Signature — Pare	nt or Legal Guardian		Date Signed		

8. Child's Special Care Needs (check all that apply)				
☐ Environmental allergies		Limitations or restrictions or	n child's activities	
☐ Food intolerances		Reasonable accommodatio	ns or modifications	
Existing illness		Adaptive equipment (includ	e instructions below)	
Previous serious illness		Symptoms or indications of complications		
☐ Injuries and hospitalizations (past 12	? months)	Medications prescribed for	continuous long-term use	
Other:				
Explain any needs selected above:				
Does your child have diagnosed food all	lergies? OYes ONo Foo	od Allergy Emergency Plan Subn	nitted Date:	
Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit <a href="https://www.ada.gov/resources/child-care-centers/">https://www.ada.gov/resources/child-care-centers/</a> . If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).				
Signature — Parent or Legal Guardia	n	Date Signed		
9. School Age Children				
My child attends the following school:			School Area Code and Phone No.:	
My child has permission to (check all the	at apply):			
walk to or from school or home	ride a bus be released to	the care of his or her sibling und	er 18 years old	
Authorized pick up or drop off locations	other than the child's address:			
☐ Child's required immunizations, visio	n and hearing screening, and Tl	B screening are current and on f	ile at their school.	
	Authorization For Emer	gency Medical Attention		
In the event I cannot be reached to arra	nge for emergency medical care	e, I authorize the person in charg	ge to take my child to:	
Name of Physician	Address		Phone No.	
Name of Emergency Care Facility	Address		Phone No.	
I give consent for the facility to secure any and all necessary emergency medical care for my child.				
Signature — Parent or Legal Guardia	ш	Date Signed		

Requirements for Exclusion from Compliance						
	I have attached a signed and dated affidavit stating that I decline immunizations for reason 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						
	enomination that I am an adherent		orming commoto with the toric	to or practiced or a charon or		
		Vision Exam Results				
Right Eye 20/	Left Eye 20/ OPas	os Orali				
Signature		Date Signed				
		Hearing Exam Results				
Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail		
Right				O Pass O Fail		
Left				O Pass O Fail		
Signature		Date Signed				
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. (Select only one option.)						
Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take						
part in the day care program.						
A signed and dated copy of a health care professional's statement is attached.						
Medical diagnosis and treatment conflict with the tenets 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.						
My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12						
months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.						
Name of Health Care Professional, if selected  Address of Health Care Professional, if selected						
Signature — H	ealth Care Professional	 Date Signed				
Signature	Signature — Parent or Legal Guardian Date Signed					
ognature — P	areni or Legar Guardian	Date Signed				

## **Vaccine Information**

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
'	1–2 months (second dose)	
	6–18 months (third dose)	
 Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
- ,	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
Taomophilao milaonza Typo B	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
Pneumococcal	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
nactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza  Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.		
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
/aricella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Varicella (Chickenpox)				
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 [dat	e] and does not need varicella vaccine.			
Signature	Date Signed			
Additional Information 6	Regarding Immunizations			
For additional information regarding immunizations, visit the Texas Dep immunize/public.shtm.	artment of State Health Services website at <u>www.dshs.state.tx.us/</u>			
TB Test (I	f required)			
O Danitina O Namatina D				
Positive Negative Date:				
Cong E	voo 7000			
	ree Zone			
Under the Texas Penal Code, any area within 1,000 feet of a child care organized criminal activity are subject to harsher penalties.	center is a gang-free zone, where criminal offenses related to			
organized driminal activity are subject to hardren perialities.				
Privacy S	Statement			
HHSC values your privacy. For more information, read our privacy polic	y online at: https://hhs.texas.gov/policies-practices-privacy#security			
Signa	atures			
Oight.	au 165			
Child's Parent or Legal Guardian	Date Signed			
Center Designee	Date Signed			
Physician or Public Heal	th Personnel Verification			
Signature or stamp of a physician or public health personnel verifying immunization information above:				
Signature	Date Signed			