ADMISSION INFORMATION

Operation Name			Director's Name		
First Foundations Preschool			Steffani Wilkins		
Child's Name	Name Child Goes By		Date of Birth	Child's Home Telephone No.	
Child's Home Address	City		State	Zip	
Date of Admission / Email Address			Hours and days child will be in care: determined by availability M-F, MWF or TTh (Start Times Vary)		
Parent's or Guardian's Name			Address (if different from child's address)		
List telephone numbers where parents/guardian may be reached while child will be in care:	Mother's Telephone No. Work: / Cell:		Father's Telephone No. Work: / Cell:	Guardian's Telephone No.	

Give the name, address and phone number of person to call in case of an emergency if parents / guardian cannot be reached:

Name:	Phone:		Relationship:
Address:	City:	State:	Zip:

I hereby authorize the childcare operation to allow my child to leave the childcare operation **ONLY** with the following persons. Please list name & telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.

Name:	Name:	Name:
Phone:	Phone:	Phone:

1. ☐ **RECEIPT OF WRITTEN OPERATIONAL POLICIES.** I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

2. ☐ WATER ACTIVITIES: I hereby ☐ give ☐ do not give -my consent for my child to participate in Water Activities:
☐ sprinkler play ☐ water table play

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:	Ph.#:
Name of Emergency Medical Care Facility:	Address:	Ph.#:

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature - Parent or Legal Guardian

List any special problems that your child may have, such as allergies, 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 caregiver's should be aware of:

Signature – Parent or Legal Guardian

Date

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title 111. If you believe that such an operation may be practicing discrimination in violation of Title 111, you may call the ADA Information Line at (800) 514-0301 (voice) or (800)-514-0383 (TTY).

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IMMUNIZATION RECORD:

☐ I have provided the childcare operation with a copy of my child's most current immunization record.

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 _____

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

3. ☐ 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.

4. ☐ 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 will submit it to the child-care operation.

Name and address of health care professional:

Signature - Parent or Legal Guardian _____ Date _____

Signature – Parent or Legal Guardian _____ Date _____

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HEALTH REQUIREMENTS

Name of Child: **Date of Birth**:

Age _ Vaccine _	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	2-3 Yrs	4-6 Yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus influenzae type b											
Pneumococccal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											

TB TEST (if required) ☐ Positive ☐ Negative Date:

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) _____ and does not need varicella vaccine.

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
www.dshs.state.tx.us/immunize/public.shtm

Signature – Parent or Legal Guardian Date