

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.

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Operation's Name			Director's N	teme				
Child's Full Name	Child'e	Date of Birth	O Both parent	8	Mom O Da	O Guardian Date of Withdrawai		
Child's Home Address								
Name of Parent or Guardian	Completing Form	Addres	s of Parent	or Guardian (if diffi	erent f	rom the child's)		
ist beiephone numbers be	low where parents/guardia	n may b	e reached	while child is in	care.	Custody Docu	ments on File	
Parent 1 Telephone No.	Parent 2 Telephone No.		Guardian	1 alahitana		O Yes	ONO	
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or emergency care	on fleid trips			and from home				
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Emergency Care	Facility	Address	sary emergency medical care for my child.										
Physician		Address	Phone Number										
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Safe sleep													
	lucting health checks												
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List any special needs that your child may have, such as environmental allergies, food intolerances, existing lilness, 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 diagnosed food allergles? OYes ONo Plan Submitted on Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. 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). Date Signed Signature -- Parent or Legal Guardian School Age Children School Phone Number My child attends the following school -My child has permission to (check all that apply): be released to the care of his/her sibling under 18 years old ride a bus walk to or from school or home Authorized pick up/drop off locations other than the child's address Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school. 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. Check only one option: 1. O 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. Signature — Health Care Professional Date Signed 2. O A signed and dated copy of a health care professional's statement is attached. 3. O 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. O 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. Address of Health Care Professional Name Date Signed Signature — Parent or Legal Guardian

Regulrements for Exclusion

have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the imm described by Section 161.0041 Health and Gafety Code submitted no later than the 90th day after the affidavit is notarized.

have attached a signed and dated affidavit etating that the vision or hearing screening conflicts with the tenets or practices of a church or digious denomination that I am an adherent or member of.

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		1-2 months (second dose)		
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18		-2 months (first dose)		
		4 months (second dose)		
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le, Tetenus, Pert	uasia	2 months (first dose)		The contract the contract of t
	Transfer Log Cotton	4 months (second dose)		
		6 months (third dose)		
		15–18 months (fourth dose)		
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dius Influenza T	уре В	2 months (first dose)		
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		6 months (third dose)		
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occal	P.America Schools Communication of the Communicatio	2 months (first dose)		
		4 months (second dose)		
		6 months (third dose)		

nactiveted Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6-18 months (third dose)	
	4-6 years (fourth dose)	
nfluenza	Yearly, starting at 8 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.	
lessies, Mumps, Rubella	12-15 months (Arst dose)	
	4-6 years (second dose)	
aricella	12–15 months (first dose)	
	4-6 years (second dose)	
epstitis A	12-23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	
	Physician or Public Health Personnel Verification	
Anema or amush or a husarcia	or public health personnel verifying immunization information. Signature	Date Signed
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	not required if your child has had chickenpox disease. If you	us child has had shiskansan sie
encella (chickenpox) vaccine is implete the statement: My child incella vaccine.	had varicella disease (chickenpox) on or about (date)	and does not need
	Signature	Date Signed
	Additional Information Regarding Immunizations	
Control of the Contro	ng immunizations, visit the Texas Department of State He	The state of the s
	TB Test (If Required)	
Positive ONegative Date:		

	Privacy Statement	
c values your privacy. For n	nore information, read our privacy policy online at: https://hhs.texas.gov/policies-prac	tices
	Signatures	
Child's Pe	arent or Legal Guardian Date Signed	
Ce	Inter Designee Date Signed	

Center Enroll Date Child's First Name		Ethnic Identity (Check one) Hispanic or Latino Not Hispanic or Latino	ONLY	1
Child's Last Name		Racial Identity (Check all that apply)	USE	1
Child's Birth Date	1 1 1	Black / African American Am. Indian / Alaskan Native	Se l	1
Normal Days in Care * Center's Days of Operation: M-F	M TH F SA SE	Asian Native Hawaiian / Other Pacific Islander	SPONS	de d
Normal Hours in Care * Center's Hours of Operation: 6:30 AM - 6:00 PM	BAM to BAM		SITE	roll Da
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Center Enroll Date	回/回/回	Ethnic Identity (Check one) Hispanic or Latino	>	1
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PARENT / GUARDIAN INFOR	MATION			
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Signature	Date	Cell Phone		

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Part 2. Benefits: If any member of	our household receiv	es SN/	AP.	TANF, or FC	PIR	pro	ovide the na	me a	and e	ligibi	lity numbe	er for		
the person who receives benefits. If NAME:	no one receives the	se ben	efit	S, skip to p ELIGIBILITY SNAP or TANF n	art 4	4. IMBI	ER:			.				
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Part 5. Signature and Last Four Di An adult household member must si of his or her Social Security Numi the next page.) I certify that all information on this for Federal funds based on the information	gn this form. If Part 4 per or mark the "I do om is true and that all tion I give. I understan	is con not ha	nplo e is CA	reported. I of	unde s ma	ity N	ing the formulation be and that the info	cent	see er or ion. i	Priva	care home	etemer	nt on	ts
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