ADMISSION INFORMATION

Operation Name		Director's Name	
KIDS R KIDS #40		Carmen Hernandez	
Child's Name		Date of Birth	Child's Home Telephone No.
Child's Home Address		Subdivision	
Date of Admission	Date of Withdrawal	Hours and days child will be in care	
Parent's or Guardian's Name			
Email Address			
List telephone numbers where parents/guardian may be reached while child will be in care:	Mother's Telephone No.	Father's Telephone No.	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:			Relationship
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.			

CHECK ALL THAT APPLY:

1. ☐ **TRANSPORTATION:** I hereby ☐ give ☐ do not give – consent for my child to be transported and supervised by the operation's employees:
☐ Check box for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. ☐ **FIELD TRIPS:** I hereby ☐ give ☐ do not give – my consent for my child to participate in Field Trips:

Parent's Comments:

3. ☐ **PHOTOGRAPHS:** I hereby ☐ give ☐ do not give – my consent for my child's photo to be used on the KRK #40 web page.

4. ☐ **WATER ACTIVITIES:** I hereby ☐ give ☐ do not give – my consent for my child to participate in Water Activities:
☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ water table play

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

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 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:

_____

_____

SCHOOL AGE CHILDREN:

☐ My child attends the following school:

_____ _____
Name of School and Address School Ph.#

CHECK ALL THAT APPLY:

☐ His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

☐ My child has permission to ☐ ride a bus, ☐ walk to and from school, and/or ☐ be released to the care of his/her sibling(s) under 18 years old.
Name of sibling(s):

Signature – Parent or Legal Guardian

Date

ADMISSION INFORMATION

HEALTH REQUIREMENTS

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

IMMUNIZATIONS	Date / dose 1	Date / dose 2	Date / dose 3	Date / dose 4	Date / booster
DTP / DTaP / DT					
POLIO IPV or OPV					
MEASLES Rubeola / Serampion					
MUMPS					
RUBELLA					
Hib					
Hepatitis A					
Hepatitis B					
TB TEST (if required)	☐ Positive	☐ Negative	Date:		
Varicella (see below)					

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

Signature of Health Care Professional _____ Date _____

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 physically 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. ☐ PARENT'S STATEMENT: 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

4. ☐ 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.

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL
SIGNATURE		DATE	

HEARING	1000 Hz	2000 Hz	4000 Hz	
R				☐ PASS ☐ FAIL
L				

SIGNATURE _____ DATE _____

_____ _____
Signature – Parent or Legal Guardian Date