

## **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.

		Ganai	ral Information			
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Operation's Name: CREATIVE CARE CHILDREN'S SCHOOL		Director's Name: BRENDA SAMUEL				
Child's Full Name:		Child's Date of Birth:	Child Lives With?  Both parents			
Child's Home Address:			Date of Admission:	Date of Withdrawal:		
Name of Parent or Guardian Completing Form:			Address of Parent or Guardian (if different from the child's):		ifferent from the child's):	
List phone numbers below where	e parents or gua	ardian may be reac	ned while child is in care.			
Parent 1 Phone No.:			Guardian's Phone No.:		Custody Documents on File?  O Yes O No	
In case of an emergency, call:						
Name of Emergency Contact:			Relationship:		Area Code and Phone No.:	
Address:						
					following persons. Please list name nated by the parent or guardian after	
Name:				Are	a Code and Phone No.:	
Name:				Are	Area Code and Phone No.:	
Name:				Area Code and Phone No.:		
		Conse	ent Information	<b>'</b>		
1. Transportation:		901130				
-	transported and	d auparvised by the	anaration's amplayage (	Chook all th	ot apply)	
I give consent for my child to be transported and supervised by the operation's employees (Check all that 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	participate in fie	eld trips. O I do n	ot give consent for my ch	nild to partici	pate in field trips.	
Comments:		1	J	'		
.[						

3. Water Activities:					
I give consent for my child to participate in the following water activities (Check all that apply).					
water table play	sprinkler play	splashing or wadi	ing pools		
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			○ Yes ○ No		
Do you want your child to wear a life jacket while in or near a swimming pool?		et while in or near a			
◯ Yes ◯ No					
4. Receipt of Written	Operational Policies	<b>5</b> :			
I acknowledge receipt	of the facility's operati	onal policies, including	those for (Check all that apply).		
☐ Discipline and guid	lance		Procedures for release of children		
Suspension and ex	kpulsion		☐ Illness and exclusion criteria		
☐ Emergency plans			Procedures for dispensing medications		
☐ Procedures for cor	nducting health checks	3	Immunization requirements for children		
☐ Safe sleep			☐ Meals and food service practices		
☐ Procedures for parents to discuss concerns with the director			Procedures to visit the center without securing prior approval		
Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions			Procedures for supporting inclusive services		
Procedures for par	ents to participate in c	peration activities	Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline, and CCR website		
5. Meals:					
I understand that the following meals will be served to my child while in care (Check all that apply):					
☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack					
6. Days and Times in	n 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 Rights:					
I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.					
Signature — Parent 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 accommodations or modifications		
Existing illness		Adaptive equipment (include	e instructions below)	
☐ Previous serious illness	Previous serious illness		complications	
☐ Injuries and hospitalizations (past 12	? months)	☐ Medications prescribed for o	continuous long-term use	
Other:				
Explain any needs selected above:				
Does your child have diagnosed food all	ergies? ()Yes ()No Foo	d 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 tha	at apply):			
☐ walk to or from school or home ☐	ride a bus	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:			
Childle required immunitations vision	n and bearing corporing, and Ti	2 according are current and an f	ilo at their cabael	
Child's required immunizations, vision	n and nearing screening, and TE	screening are current and on t	ile at their school.	
	Authorization For Emerg	gency Medical Attention		
In the event I cannot be reached to arrai	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	n	Date Signed		

	Rea	uirements for Exclusion from	Compliance			
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 religious denomination that I am an adherent or member of.						
		Vision Evam Posults				
Vision Exam Results						
Right Eye 20/ OPass OFail						
Signature	Signature Date Signed					
		Hearing Exam Results				
Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail		
Right				Pass Fail		
Left				Pass Fail		
Signature		Date Signed	1			
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 — Health Care Professional		Date Signed				
Signature — Parent or Legal Guardian		 Date Signed				

## **Vaccine Information**

The following vaccines require multip	le doses over time. Please provide the date your child received e	each dose.
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)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated 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 [da	te] and does not need varicella vaccine.			
	_			
Signature	Date Signed			
Signature	Date Signed			
Additional Information F	Regarding Immunizations			
For additional information regarding immunizations, visit the Texas Depimmunize/public.shtm.	partment of State Health Services website at <u>www.dshs.state.tx.us/</u>			
TR Too! //	f voguined)			
IB lest (I	If required)			
Positive Negative Date:				
Gang F	ree Zone			
Under the Texas Penal Code, any area within 1,000 feet of a child care	center is a gang-free zone, where criminal offenses related to			
organized criminal activity are subject to harsher penalties.				
Privacy S	Statement			
HHSC values your privacy. For more information, read our privacy polic	cy online at: https://bhs.tevas.gov/policies-practices-privacy#security			
Throco values your privacy. For more information, road our privacy point	y offinite at. https://mis.toxas.gov/policies/practices/privacy/raccanty			
Sign	atures			
Child's Parent or Legal Guardian	Date Signed			
Center Designee	Date Signed			
Physician or Public Health Personnel Verification				
Signature or stamp of a physician or public health personnel verifying immunization information above:				
Signature	Date Signed			