

Kiddos of Katy

Learning Center

Admission Information

Operation Name Kiddos of Katy Learning Center		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:	
		Date of Withdrawal:	
Name of Parent or guardian Completing Form:	Phone Number	Address (if different from child's address)	
Mothers first and last Name		Address (if different from child's address)	
Fathers first and last Name		Address (if different from child's address)	
Mothers Email:		Fathers Email:	
Guardian's first and last Name		Address (if different from child's address)	
List telephone numbers below where parents/guardian may be reached while child will be in care:			
Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.	Cell Phone No
Give the name, address and phone number of persons to call in case of an emergency if parents / guardian cannot be reached:			Relationship
Give the name, address and phone number of persons to call in case of an emergency if parents / guardian cannot be reached:			Relationship
I authorize the child care operation to release my child to leave the child care operation only with the following persons. Please list name and telephone number for each. Children will only be released to a parent or guardian or to a persons designated by the parent or guardian after verification of ID.			
Full Name:		Address:	Telephone No.
Full Name:		Address:	Telephone No.
Full Name:		Address:	Telephone No.
Full Name:		Address:	Telephone No.
Full Name:		Address:	Telephone No.
Full Name:		Address:	Telephone No.

Parent Signature _____ Date: _____



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CHILD'S NAME _____

Admission Information

Check all that Apply:

1. Transportation

I give consent for my child to be transported and supervised by the operation's employees:

For Emergency Care On Field Trips To and From School

2. Field Trips

I give consent for my child to participate in field trips I DO NOT give consent for my child to participate in field trips.

Comments:

3. Water Activities

I give consent for my child to participate in the following water activities:

water table play Sprinkler Play Splashing/wading pools swimming pools aquatic playgrounds

Comments:

4. receipt of written Operational policies

I acknowledge receipt of the facilities operational policies, including those for:

- | | |
|--|---|
| <input type="checkbox"/> Discipline and guidance | <input type="checkbox"/> Procedures for release of children |
| <input type="checkbox"/> Suspension and expulsion | <input type="checkbox"/> Illness and exclusion criteria |
| <input type="checkbox"/> Emergency Plans | <input type="checkbox"/> Procedures for dispensing medications |
| <input type="checkbox"/> Procedures for conducting health checks | <input type="checkbox"/> Immunization requirements for children |
| <input type="checkbox"/> Safe Sleep | <input type="checkbox"/> Meals and food service practices |
| <input type="checkbox"/> Procedures for parents to discuss concerns
With the Director | <input type="checkbox"/> Procedures to visit the center without securing prior
Approval |
| <input type="checkbox"/> Procedures for parents to participate in operation activities | <input type="checkbox"/> Procedures for parent s to contact Child Care
Licensing, DPS, Child Abuse Hotline, and CCCL website |

5. Meals

I understand that the following meals will be served to y child while in care:

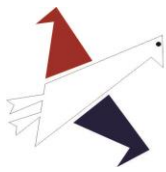
None Breakfast Morning Snack Lunch Afternoon Snack Evening Snack

6. Days and times in Care

My child will normally be in care on the following days and times:

Monday	____: ____ AM	____: ____ PM
Tuesday	____: ____ AM	____: ____ PM
Wednesday	____: ____ AM	____: ____ PM
Thursday	____: ____ AM	____: ____ PM
Friday	____: ____ AM	____: ____ PM

Parent Signature _____ Date: _____



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CHILD'S NAME _____

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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 of Physician	Phone Number
Name of Emergency Care Facility	Address of Emergency Care Facility	Phone Number

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

Signature of Parent or Legal Guardian _____

Date of Signature _____

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.

Check only one option:

1. ____ Health Care Professional's Statement: I have examined the above-named child within the past year and find that the He or She is able to take part in the day care program.

Signature of Health Care Professional

Date Signed

2. ____ A signed and dated copy of a health care professional's statement is attached.
3. ____ Medical diagnosis and treatment conflict with the tenet's ad 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 daycare program. Within 12 months of admission, I will obtain a health care professional's statement and submit it to the child care operation.

Name of Health Care Professional	Address of Heath Care Professional	Phone number
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Signature of Parent or Legal Guardian

Date of Signature

List any special needs that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months. Any medication prescribed for long-term use, and any other information which caregivers should be aware of:

Does your child have diagnosed food allergies? ____ Yes ____ No 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 or (800)514-0383(TTY)

Signature of Parent or Legal Guardian

Date Signed

Parent Signature _____ Date: _____



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CHILD'S NAME _____ **Admission Information**

Requirements for Exclusion

_____ 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 o 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 and Hearing Exam Results

VISION	R 20/ _____	L 20/ _____	PASS	FAIL	
PROVIDER SIGNATURE _____	DATE _____				
HEARING	1000 Hz	2000 Hz	4000 Hz	PASS	FAIL
R					
L					
PROVIDER SIGNATURE _____	DATE _____				

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, and/or

be released to the care of his/her sibling(s) under 18 years old.

Name of sibling(s): _____

Vaccine Information

The following vaccines require multiple doses over time. A copy for your child's up to date immunization record with physician or public health personnel verifying signature required for admission to our school.

Hepatitis B – (first dose) Birth, (second dose) 1-2 Months (third dose) 6-18 Months

Rotavirus – (first Dose) 2 Months (second dose) 4 months (third dose) 6 months

Diphtheria, Tetanus, Pertussis – (first dose) 2 months (second dose) 4 months (third dose) 6 months (fourth dose) 12-15 months

Haemophilus Infuenzae type b – (first dose) 2 months (second dose) 4 months (third dose) 6 months (fourth dose) 12-15 months

Pneumococcal- (first dose) 2 months (second dose) 4 months (third dose) 6 months (fourth dose)

Inactivated Poliovirus – (first dose) 2 months (second dose) 4 months (third dose) 6-18 months (fourth dose) 4-6 years

Influenza – yearly, starting at 6 months. Two doses given at least 4 weeks apart are recommended for the first-time recipients

Measles, Mumps, Rubella – (first dose) 12-15 months (second dose) 4-6 years

Varicella – (first dose) 12-15 months (second dose) 4-6 years

Hepatitis A – (first dose) 12-23 months (second dose) should be given 6-18 months after the first dose

Parent Signature _____ Date: _____



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CHILDS NAME _____ **Admission Information**

Varicella (Chickenpox)

Varicella (Chickenpox) vaccine is not required if your child has had the chickenpox disease. If your child has had chickenpox, please complete the statement: My child had the varicella disease(chickenpox) on or about (date)_____ and does not need the varicella vaccine.

Parent or guardian signature

Date signed

Additional information regarding immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dsh.state.tx.us/immunize/public.shtm.

TB Test (If required)

_____ Positive _____ Negative Date: _____

Gang Free Zone

Under the Texas Penal Code, any area with 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,

Parent or Legal Guardian Signature

Date signed

Center Designee

Date signed

Parent Signature _____ Date: _____