

ADMISSION INFORMATION

| | | | |
|--|------------------------|---|----------------------------|
| Operation Name Promise Land Learning Center | | Director's Name Patsy Givens | |
| Child's Name | | Date of Birth | Child's Home Telephone No. |
| Child's Home Address | | | |
| Date of Admission | Date of Withdrawal | Hours and days child will be in care | |
| 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. | 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. <input type="checkbox"/> TRANSPORTATION: | I hereby <input type="checkbox"/> give | <input type="checkbox"/> do not give – consent for my child to be transported and supervised by the operation's employees. | |
| | <input type="checkbox"/> for emergency care | <input type="checkbox"/> on field trips | <input type="checkbox"/> to and from home <input type="checkbox"/> to and from school |
| 2. <input type="checkbox"/> FIELD TRIPS: | I hereby <input type="checkbox"/> give | <input type="checkbox"/> do not give – my consent for my child to participate in Field Trips: | |
| Parent's Comments: | | | |
| 3. <input type="checkbox"/> WATER ACTIVITIES: | I hereby <input type="checkbox"/> give | <input type="checkbox"/> do not give – my consent for my child to participate in Water Activities: | |
| | <input type="checkbox"/> sprinkler play | <input type="checkbox"/> splashing/wading pools | <input type="checkbox"/> swimming pools <input type="checkbox"/> water table play |
| 4. <input type="checkbox"/> 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 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:

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that a such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 414-0301 (voice) or (800)-514-0383 (TTY).

| | |
|---|--|
| SCHOOL AGE CHILDREN: | |
| <input type="checkbox"/> My child attends the following school: | |
| _____ Name of School and Address | _____ School Ph.# |
| CHECK ALL THAT APPLY: | |
| <input type="checkbox"/> 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. | <input type="checkbox"/> My child has permission to <input type="checkbox"/> ride a bus, <input type="checkbox"/> walk to and from school, <input type="checkbox"/> be released to the care of his/her sibling(s) under 18 years old. and/or |
| 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 |
| Hepatitis B | | | | | |
| DTP / DTaP / DT | | | | | |
| Hib | | | | | |
| POLIO IPV or OPV | | | | | |
| MEASLES | | | | | |
| MUMPS | | | | | |
| RUBELLA | | | | | |
| Varicella (see below) | | | | | |
| Pneumococcal Conjugate Vaccine | | | | | |
| Hepatitis A | | | | | |
| TB TEST (if required) <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: _____ | | | | | |
| Signature or stamp of a physician or public health personnel verifying immunization information above. _____ <div style="display: flex; justify-content: space-between;"> Signature Date </div> | | | | | |
| 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 _____ | |
| <input type="checkbox"/> 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 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:

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

Name and address of health care professional:

 Signature - Parent or Legal Guardian Date _____

| | | | |
|-----------------|-------------|-------------|---|
| VISION | R 20/ _____ | L 20/ _____ | <input type="checkbox"/> PASS <input type="checkbox"/> FAIL |
| SIGNATURE _____ | | DATE _____ | |
| HEARING | 1000 Hz | 2000 Hz | 4000 Hz |
| R | | | |
| L | | | |
| | | | <input type="checkbox"/> PASS <input type="checkbox"/> FAIL |
| SIGNATURE _____ | | DATE _____ | |

Signature – Parent or Legal Guardian

Date