REGISTRATION FORM

KID SPACE Drop-in Child Care		Director: Betsy Garrett Estrada
Child's Name:	Date of Birth:	Home Phone #:
Address:		
Date of Admission:	Hours child will be in care: [ ] Part-time [ ] Drop-in care only.	
Parent's or Guardian's Name:		
Parent's or Guardian's Address (if different from child's):		
Mother's Phone #: Work: Cell:	Father's Phone #: Work: Cell:	Guardian's Phone #: Work: Cell:
Name of person to call if Parent or Guardian can't be reach:	Home phone #: Work: Cell:	Address: Relationship to Child:

My child is allowed to leave the childcare facility with the following persons ONLY:

Name/Phone #:	Name/Phone #:
Name/Phone #:	Name/Phone #:

I acknowledge receipt of Kid Space's Parent Brochure, Operational Policy and understand that all purchases and fees are neither refundable nor transferable:
Parent or Guardian Signature: Date:

IMMUNUNINIZATION REQUIREMENT PLEASE CHECK ONE:

[ ] His/Her immunization record is on file at the school and all immunizations are current. Vision and Hearing screening records are also on file.

School Name:____________________________________ Phone Number:(_____) _____ - __________

Address:______________________________________ City:______________ State:_____ Zip:________

[ ] Immunizations records attached.

[ ] Immunization exclusion or exemption signed affidavit attached.

[ ] Medical Reasons. [ ] Conscience Reasons.(TAC Title 25 Prt 1 Chp 97 SChp B Rule §97.62)

Signature:________________________________ Date:_________________________

List any special problems your child may have including any allergies, chronic illness, previous serious illnes or injuries with in the last 12 months, any long-term medication, and any other information you feel the staff should be aware of to help them better care for your child:

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AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that I can not be reached to make arrangements for emergency medical attention, I authorize the person in charge to make such arrangements:

Physician:	Address:	Phone #
Hospital: North Central Baptist	Address: 520 Madison Oak, S.A. TX 78258	Phone #: (210) 297-4050

ADMISSION REQUIREMENT FOR CHILDREN UNDER AGE 5:

One of the following must be present for your child within one week of admission to the daycare facility:

[ ] HEALTH-CARE PROFFESIONAL'S STATEMENT: I have examinated the above named child within the past year and find that he/she is physically able to take part in the daycare program.

Health Care Proffesional's signature: ______________________________ Date: _________

[ ] PARENT'S STATEMENT: My child has been examinated within the past year by a health care proffesional and is able to participate in the daycare program.

Name and Address of Health Care Professional:___________________________________

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[ ] Within 12 months of admission, I will obtain a Health Care Professional's statement and will submit it to the daycare facility.

SIGNATURE OF PARENT OR GUARDIAN: _________________________________
Date:____________

[ ] I understand that theDirector will be available to address any questions or concerns I may have concerning policies and procedures and that I will be notified in wrinting of any Center Policy chances.

KS Form 103 Rev: 16 October 2019