October 2023

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.

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| **General Information** | | | | | | |
| Operation’s Name: | | 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: | | Address of Parent or Guardian *(if different from the child's)*: | | | | |
| List phone numbers below where parents or guardian may be reached while child is in care. | | | | | | |
| Parent 1 Phone No.: | Parent 2 Phone No.: | Guardian's Phone No.: | | | Custody Documents on File?  Yes  No | |
| **In case of an emergency, call:** | | | | | | |
| Name of Emergency Contact: | | Relationship: | | | Area Code and Phone No.: | |
| Address: | | | | | | |
| 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 phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID. | | | | | | |
| Name: | | | | Area Code and Phone No.: | | |
| Name: | | | | Area Code and Phone No.: | | |
| Name: | | | | Area Code and Phone No.: | | |

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| **Consent Information** |
| **1. Transportation:** |
| 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 field trips.  I do not give consent for my child to participate in field trips. Comments: |

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| **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 wading pools swimming pools aquatic playgrounds | | | | |
| Is your child able to swim without assistance?  Yes  No | | | | Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming?  Yes  No |
| Do you want your child to wear a life jacket while in or near a swimming pool?  Yes  No | | | |  |
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| **4. Receipt of Written Operational Policies:** | | | | |
| I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).  Discipline and guidance Procedures for release of children  Suspension and expulsion Illness and exclusion criteria  Emergency plans Procedures for dispensing medications  Procedures for conducting health checks 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 Procedures for supporting inclusive services criteria for extreme weather conditions  Procedures for parents to participate in operation 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 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 |  |  |

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| **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**

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| **8. Child's Special Care Needs (check all that apply)** |
| Environmental allergies Limitations or restrictions on child's activities  Food intolerances Reasonable accommodations or modifications  Existing illness Adaptive equipment *(include instructions below)*  Previous serious illness Symptoms or indications of complications  Injuries and hospitalizations *(past 12 months)* Medications prescribed for continuous long-term use Other:  Explain any needs selected above: |
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| Does your child have diagnosed food allergies? Yes  No Food Allergy Emergency Plan Submitted Date:  Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit https:// [www.ada.gov/resources/child-care-centers/.](http://www.ada.gov/resources/child-care-centers/) 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 Guardian Date Signed** |

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| **9. School Age Children** | |
| My child attends the following school: | School Area Code and Phone No.: |
| My child has permission to *(check all that apply)*:  walk to or from school or home ride a bus be released to the care of his or her sibling under 18 years old | |
| Authorized pick up or drop off locations other than the child’s address:  Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school. | |

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| **Authorization For Emergency Medical Attention** | | |
| In the event I cannot be reached to arrange for emergency medical care, I authorize the person in charge 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 Guardian Date Signed** | | |

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| **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. |

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| **Vision Exam Results** | | | | |
| Right Eye 20/  **Signature** | Left Eye 20/ | Pass | Fail | **Date Signed** |

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| **Hearing Exam Results** | | | | |
| **Ear** | **1000 Hz** | **2000 Hz** | **4000 Hz** | **Pass or Fail** |
| Right |  |  |  | Pass  Fail  Pass  Fail |
| Left |  |  |  |
| **Signature Date Signed** | | | | |

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| **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 |

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| **Vaccine Information** | | |
| The following vaccines require multiple doses over time. Please provide the date your child received 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) |  |
| Varicella | 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. |  |

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| **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 [date] and does not need varicella vaccine.    **Signature Date Signed** |

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| **Additional Information Regarding Immunizations** |
| For additional information regarding immunizations, visit the Texas Department of State Health Services website at [www.dshs.state.tx.us/](http://www.dshs.state.tx.us/) immunize/public.shtm. |

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| **TB Test (If required)** |
| Positive Negative Date: |

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| **Gang Free 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. |

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| **Privacy Statement** |
| HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security |

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| **Signatures** |
| **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** |