

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.

General Information				
Operation's Name: Precious Lambs Learning Center	#2	Director's Name: La Shawn Williams		
Child's Full Name:		Child's Date of Birth:	Child Lives	
Child's Home Address:		Date of Admission:		Date of Withdrawal:
Name of Parent or Guardian Com	pleting Form:	Address of Parent or Guardian (if different from the child's):		
List phone numbers below where	parents or guardian may be read	hed while child is in care.		
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:		Custody Documents on File?
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.:		Code and Phone No.:
Name: Area Code and Phone No.:			Code and Phone No.:	
Name:			Area	Code and Phone No.:
Consent Information				
1. Transportation:				
-	apapartad and aupanvised by the	operation's employees (Chook all that	opply)
I give consent for my child to be tr				appiy).
☐ 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 wadir	ng pools 🔲 swimming pools 🗌 aquatic playgrounds	
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 o swimming pool? ◯ Yes ◯ No	child to wear a life jacke	et while in or near a		
4. Receipt of Written	Operational Policies	:		
I acknowledge receipt	of the facility's operatic	nal policies, including t	hose for (Check all that apply).	
Discipline and guid	ance		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		Immunization requirements for children	
Safe sleep			☐ Meals and food service practices	
Procedures for par	ents to discuss concer	ns with the director	Procedures to visit the center without securing prior approval	
Promotion of indoor and outdoor physical activity including		l activity including	Procedures for supporting inclusive services	
Procedures for parents to participate in operation activities		peration activities	\Box Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline, and CCR website	
5. Meals:				
I understand that the f	following meals will be	served to my child whi	le 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.	Р.М.		
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.

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 instructions below)	
Previous serious illness		Symptoms or indications of complications	
Injuries and hospitalizations (past 12)	? months)	Medications prescribed for c	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 acc			
www.ada.gov/resources/child-care-center may call the ADA Information Line at (80			rimination in violation of Title III, you
Signature — Parent or Legal Guardiar	1	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	t apply):		
walk to or from school or home	ride a bus De released to t	he care of his or her sibling und	er 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.			
	Authorization For Emor		
	Authorization For Enler	gency Medical Attention	
In the event I cannot be reached to arrar			e to take my child to:
In the event I cannot be reached to arran Name of Physician			e to take my child to: Phone No.

Name of Physician	Address		Phone No.
,			
Name of Emergency Care Facility	Address		Phone No.
Children's Hospital	1935 Medical District, Dallas, TX 75235		(214) 456-7000
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			
	tached a signed and dated affidavit s cribed by Section 161.0041 Health a	tating that I decline immunizations	for reason of conscience, includir	
_ I have at	tached a signed and dated affidavit si denomination that I am an adherent	tating that the vision or hearing scr	•	
Teligious				
		Vision Exam Results	;	
Right Eye 20	/ Left Eye 20/ OPass	s ()Fail		
0:				
Signature		Date Signe	d	
		Hearing Exam Result	S	
Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				🔿 Pass 🔵 Fail
Left				🔿 Pass 🔵 Fail
				I
0			<u> </u>	
Signature		Date Signe	d	
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				
\bigcirc 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				
		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	l 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 chic	kenpox 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
Additional Information	Regarding Immunizations
For additional information regarding immunizations, visit the Texas Dep immunize/public.shtm.	partment of State Health Services website at <u>www.dshs.state.tx.us/</u>
TB Test (If required)
OPositive ONegative Date:	
Gang E	ree Zone
Under the Texas Penal Code, any area within 1,000 feet of a child care	
organized criminal activity are subject to harsher penalties.	center is a gang-free zone, where criminal offenses related to
Privacy	Statement
HHSC values your privacy. For more information, read our privacy polic	cy online at: <u>https://hhs.texas.gov/policies-practices-privacy#security</u>
Sign	atures
Child's Parent or Legal Guardian	Date Signed
Center Designee	Date Signed
Physician or Public Hea	Ith Personnel Verification
Signature or stamp of a physician or public health personnel verifying in	nmunization information above:
Signature	Date Signed
Parent 1 Email Address:	
Parent 2 Email Address:	
Please list any additional email addresses for individuals v access to our SmartCare system.	who will possible pickup/drop off students and will need
Email:	
Email:	