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DearOnes Daycare & Preschool

8061 S. Hulen St.

Ft. Worth, TX 76123

817-761-6900

info@dearonesdaycare.com

**ADMISSION INFORMATION**

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| Operation Name – **DearOnes Daycare & Preschool** | Director’s Name – R.C. |
| Child’s Full Name  | Child’s Date of Birth  | Child’s Home Telephone No.  |
| Child’s Home Address  |
| Date of Admission  | Date of Withdrawal  |
| Parent’s or Guardian’s 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  |
| 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.  |

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| **CHECK ALL THAT APPLY:** **1. TRANSPORTATION:**  | I hereby Give  or Do Not Give |  consent for my child to be transported and supervised by the operation’s employees:  |
| **Walk home**  | for emergency care  | on field trips  | to and from home  | to and from school  |
| **2. FIELD TRIPS:**  | I hereby give do not give  |  my consent for my child to participate in Field Trips:  |
| **Parent’s Comments:**  |
| **3. WATER ACTIVITIES:**  | I hereby give do not give  |  my consent for my child to participate in Water Activities:  |
| sprinkler play  | splashing/wading pools  | swimming pools  | water table play  |
| **4. RECEIPT OF WRITTEN OPERATIONAL POLICIES:** I acknowledge receipt of the facility’s operational policies including those for discipline and guidance.  |
| **5. I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:** None  Breakfast  AM Snack  Lunch  PM Snack  Supper Evening Snack  |
| Image result for bee clipart**6**. **MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:** Mondays from: to: Tuesdays from: to: Wednesdays from: to: Thursdays from: to: Fridays from: to:  |
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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:  | 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  |

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| **SCHOOL AGE CHILDREN (Siblings)** |
| My child attends the following school:  |
| Name of School and Address  | School Ph.#  |
| * **CHECK ALL THAT APPLY:**
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| His / her immunization record is on file at the school and allrequired immunizations and/or tuberculosis test are current.Vision and Hearing screening records are also on file. | My child has permission to:  | walk to or from school or home, Yes  No  |
|  ride a bus, and/or  |  be released to the care of his/her sibling(s) under 18 years old. Yes  No  |
| Name of sibling(s):  |

**IMMUNIZATION RECORD:**

I have provided the childcare operation with a copy of my child’s most current immunization record

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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. Please check only one option: 1.HEALTH-CARE PROFESSIONAL’S STATEMENT: I have examined the above-named child within the past year and find that he / she is able to take part in the day care program.  |
| Health Care Professional's Signature  | Date  |
| 2. A signed and dated copy of a health care professional’s statement is attached.  |
| 3 . 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. 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. |
| 4. My  |
| Name and address of health care professional:  |
| Signature - Parent or Legal Guardian  | Date  |
| **VISION**  | R 20/ \_\_\_\_\_\_\_\_  | L 20/ \_\_\_\_\_\_\_\_  | PASS  FAIL  |
| SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Image result for bee clipartDATE **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| **HEARING**  | **1000 Hz**  | **2000 Hz**  | **4000 Hz**  |
| **R**  | PASS  FAIL  |
| **L**  |
| SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Signature – Parent or Legal Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |