

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.

	Genera	al Information			
Operation's Name:		Director's Name:			
Allstars Daycare & Preschool LLC		Mrs.Tonya Hicks			
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):		fferent from the child's):	
List phone numbers below where parents or gi	uardian may be reache	ed 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 and phone number for each. Children will only verification of ID.					
Name:			Area Code and Phone No.:		
Name:			Area Code and Phone No.:		
Name:			Area Code and Phone No.:		
	Conser	nt Information			
1. Transportation:					
I give consent for my child to be transported ar	nd supervised by the o	 peration's employees (0	Check all tha	t apply).	
☐ for emergency care ☐ on field trips	to and from hor	me	chool		
2. Field Trips:					
O I give consent for my child to participate in f	field trips. OI do not	give consent for my chi	ld to participa	ate in field trips.	
Comments:					

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	3. Water Activities:				
I give consent for	my child to participa	ate in the following w	vater	activities (Check all that apply).	
water table play	sprinkler play	splashing or wadi	ng po	ols	
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 child to wear a life jacket while in or near a swimming pool?					
◯ Yes ◯ No					
4. Receipt of Written	Operational Policies	:			
I acknowledge receipt	of the facility's operation	nal policies, including	those	for (Check all that apply).	
Discipline and guid	ance		F	Procedures for release of children	
Suspension and ex	kpulsion		☐ Illness and exclusion criteria		
☐ Emergency plans			F	Procedures for dispensing medications	
Procedures for con	ducting health checks		I	mmunization 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 criteria for extreme weather conditions			Procedures for supporting inclusive services		
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 f	ollowing meals will be	served to my child wh	ile in d	are (Check all that apply):	
☐ None ☐ Brea	☐ 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			1		
Wednesday			1		
Thursday			1		
Friday			1		
Saturday			1		
Sunday					
7. Receipt of Parent's Rights:					
I acknowledge I have	received a written copy	y of my rights as a par	ent or	guardian of a child enrolled at this facility.	
-	Signature — Parer	nt or Legal Guardian			

8. Child's Special Care Needs (check	all that apply)			
Environmental allergies		Limitations or restrictions or	n child's activities	
Food intolerances		Reasonable accommodatio	ns or modifications	
Existing illness		Adaptive equipment (includ	e instructions below)	
Previous serious illness		Symptoms or indications of	complications	
☐ Injuries and hospitalizations (past 12	2 months)	Medications prescribed for o	continuous long-term use	
Other:				
Explain any needs selected above:				
Does your child have diagnosed food al	lergies? OYes ONo Fo	od Allergy Emergency Plan Subr	nitted Date:	
Child day care operations are public acc www.ada.gov/resources/child-care-cent may call the ADA Information Line at (8	ters/. If you believe that such an	operation may be practicing disc		
Signature — Parent or Legal Guardia	n	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	at apply):			
walk to or from school or home	ride a bus	the 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, visio	n and hearing screening, and T	B screening are current and on fil	le at their school.	
	Authorization For Eme	rgency Medical Attention		
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	o, radanoneo ano porcen in ondre	Phone No.	
,				
Name of Emergency Care Facility	Address		Phone No.	
I give consent for the facility to secure a	nny and all necessary emergenc	y medical care for my child.	,	
Signature — Parent or Legal Guardia	n	Date Signed		

	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	of member of.			
		Vision Exam Results			
Right Eye 20/ Pass Fail					
Signature		Date Signed			
		Hearing Exam Results			
Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail	
Right				O Pass O Fail	
Left				Pass Fail	
Signature		Date Signed			
Admission F	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					
opart 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 Car	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	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.	

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 [da	te] and does not need varicella vaccine.			
				
Signature	Date Signed			
Additional Information	Regarding Immunizations			
For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/ immunize/public.shtm .				
TB Test (If required)			
Positive Negative Date:				
Gang F	ree 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.				
Privacy Statement				
HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security				
Sign	atures			
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			