

ADMISSION INFORMATION

Operation Name Little Steps Children's Center		Director's Name Amy McCormick	
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 Email	
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 person 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.			

CHECK ALL THAT APPLY:		I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give		– consent for my child to be transported and supervised by the operation's employees:	
1. <input type="checkbox"/> TRANSPORTATION:		<input type="checkbox"/> for emergency care <input type="checkbox"/> on field trips <input type="checkbox"/> from school			
2. <input type="checkbox"/> FIELD TRIPS:		I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give		– my consent for my child to participate in Field Trips:	
Parent's Comments:					
3. <input type="checkbox"/> WATER ACTIVITIES:		I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give		– my consent for my child to participate in Water Activities:	
		<input type="checkbox"/> sprinkler play <input type="checkbox"/> splashing/wading pools <input type="checkbox"/> water table play			
4. <input type="checkbox"/> 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:					
<input type="checkbox"/> None <input checked="" type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input checked="" type="checkbox"/> Lunch <input checked="" type="checkbox"/> PM Snack <input type="checkbox"/> Evening Snack					
6. MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:					
<input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wedn. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri.		From:		To:	
SCHOOL AGE CHILDREN:					
My child attends the following school:					
<input type="checkbox"/>					
Name of School and Address			School Ph.#		
CHECK ALL THAT APPLY:					
<input type="checkbox"/> His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.			My child has permission to: <input type="checkbox"/> walk to or from school or home, <input type="checkbox"/> ride a bus, and/or		

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: MEMORIAL HERMANN HOSPITAL SW	Address: 7600 BEECHNUT ST, HOUSTON, TX,77074	Ph.#: 713-456-5000
I give consent for the facility to secure any and all necessary emergency medical care for my child.		
Signature - Parent or Legal Guardian		

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of:

Does your child have diagnosed food allergies? Yes No **Plan submitted on:** _____
 Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. 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

Name of child: _____	Date of Birth: _____
----------------------	----------------------

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

Immunizations	Date/ Dose 1	Date/ Dose 2	Date/ Dose 3	Date/ Dose 4	Date/ Booster
Hepatitis B					
DPT/Dtap/DT					
HIB					
Polio IPV/OPV					
Measles					
Mumps					
Rubella					
Varicella					
Pneumococcal					
Hep A					
T.B Test (If Required)					

Signature or Stamp of Physician or Public Health Personnel verifying immunization information above. _____
Date

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.

Parent's signature **Date**

I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

For additional information regarding immunizations contact the Department of State Health Services at www.dshs.state.tx.us/immunize/public.shtm

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.

4. 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 will submit it to the child-care operation.

Name and address of health care professional:

Signature - Parent or Legal Guardian **Date**

VISION	R 20/ _____	L 20/ _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE _____		DATE _____	
HEARING	1000 Hz	2000 Hz	4000 Hz
R			
L			
SIGNATURE _____			<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE _____		DATE _____	

Signature – Parent or Legal Guardian

Date