

# *Welcome to Hempstead ISD!*



**We have a wonderful opportunity for you and your 2-5 year old children! As a benefit to district employees, we have a state licensed daycare program that is a part of our Early Childhood Special Education (ECSE) Program formerly Preschool Program for Children with Disabilities (PPCD).**

In this program, “typical peers” are the daycare component of the ECSE program. The typical peers are able to be “role models” and the children with disabilities learn from these children while in turn teaching “sensitivity” to their peers. Past experience has shown that the typical peers have acquired early reading and math skills, and in turn become better prepared for the more structured kindergarten classroom. As an additional benefit, the hours are flexible for district employees and the cost is \$250 per month.

## **Requirements:**

- ♦ Parents/Grandparents must be district employees.
- ♦ Children must be between the ages of 2-5.
- ♦ No identified disability conditions

**If you are interested, please call Courtney Williams, Director of Special Education at 979.826.3304, Ext. 240. At this time, openings are dependent upon enrollment when school is dismissed for summer.**

## ADMISSION INFORMATION

Operation Name <b>Hempstead ISD Preschool Class</b>		Director's Name <b>Courtney Williams</b>	
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 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 <b>ONLY</b> 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.			

<b>CHECK ALL THAT APPLY:</b>		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:	
<b>1. <input type="checkbox"/> TRANSPORTATION:</b>					
Walk home		<input type="checkbox"/> for emergency care	<input type="checkbox"/> on field trips	<input type="checkbox"/> to and from home	<input type="checkbox"/> to and from school
<b>2. <input type="checkbox"/> FIELD TRIPS:</b>		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:					
<b>3. <input type="checkbox"/> WATER ACTIVITIES:</b>		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"/> swimming pools	<input type="checkbox"/> water table play
<b>4. <input type="checkbox"/> RECEIPT OF WRITTEN OPERATIONAL POLICIES:</b>		I acknowledge receipt of the facility's operational policies including those for discipline and guidance.			
<b>5. I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:</b>					
<input type="checkbox"/> None	<input type="checkbox"/> Breakfast	<input type="checkbox"/> AM Snack	<input type="checkbox"/> Lunch	<input type="checkbox"/> PM Snack	<input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack
<b>6. MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:</b>					
<input type="checkbox"/> Mondays	from:		to:		
<input type="checkbox"/> Tuesdays	from:		to:		
<input type="checkbox"/> Wednesdays	from:		to:		
<input type="checkbox"/> Thursdays	from:		to:		
<input type="checkbox"/> Fridays	from:		to:		
<input type="checkbox"/> Saturdays	from:		to:		
<input type="checkbox"/> Sundays	from:		to:		

<b>AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:</b>		
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		

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:

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

## SCHOOL AGE CHILDREN:

☐ My child attends the following school:

\_\_\_\_\_  
Name of School and Address

\_\_\_\_\_  
School Ph.#

## CHECK ALL THAT APPLY:

☐ 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: ☐ walk to or from school or home,  
☐ ride a bus, and/or ☐ be released to the care of his/her sibling(s) under 18 years old.

Name of sibling(s): \_\_\_\_\_

## IMMUNIZATION RECORD:

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

**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

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

\_\_\_\_\_  
Signature – Parent or Legal Guardian

\_\_\_\_\_  
Date

# ADMISSION INFORMATION

## HEALTH REQUIREMENTS

Name of Child:

Date of Birth:

Age ►  
Vaccine ▼

Birth

1 mos

2 mos

4 mos

6 mos

12 mos

15 mos

18 mos

19-23  
Mos

2-3 Yrs

4-6 Yrs

Hepatitis B

Rotavirus

Diphtheria, Tetanus,  
Pertussis

Haemophilus  
influenzae type b

Pneumococcal

Inactivated Poliovirus

Influenza

Measles, Mumps,  
Rubella

Varicella

Hepatitis A

Meningococcal

TB TEST (if required)

☐ Positive

☐ Negative

Date:

Signature or stamp of a physician or public health  
personnel verifying immunization information above.

Signature

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](http://www.dshs.state.tx.us/immunize/public.shtm)

Signature – Parent or Legal Guardian

Date

**Purpose:**

These questions are designed to give you the information needed to provide the best, most appropriate care for children. This information is confidential and parents must be reassured it will not be shared without their written permission.

Experts in the field recommend completing an assessment form for each child. It can help start mutual trust and respect that will develop into a strong, cooperative partnership between parents and caregivers.

The assessment should be completed prior to enrollment. Give parents an opportunity to review your enrollment forms and parent handbook before you complete the assessment form. The parent handbook or operational policies set forth your program's philosophy and values.

The enrollment interview is the time to obtain critical information about the child and provide information on your program's operational policies, such as health checks (if conducted), procedures for the release of children, and illness and exclusion criteria. It also provides parents an opportunity to assess your program and determine if it is best suited for their child's needs.

# Child Assessment Form

<b>Child Name (last, first, middle)</b>		<b>Social Security No.*</b>	<b>Enrollment Date</b>	<b>Date of Birth</b>
<b>Street Address (if rural, attach directions)</b>		<b>City</b>	<b>County</b>	<b>Zip</b>
<b>Mailing Address (if different) -- Street or P.O. Box</b>		<b>City</b>	<b>County</b>	<b>Zip</b>
<b>Telephone No. (include A/C)</b>				

\* If applicable.

## 1. Health

Does your child have any allergies?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, what allergies does your child have?			
How should we respond if he/she has an allergic reaction?			
Does your child have an existing illness?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your child taking any medication?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, how is the medication administered, and will it need to be administered while he/she is in care?			
Is the medication prescribed for continuous use?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any side effects we should be alerted to?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

## 2. Toileting:

Does your child need assistance with toileting?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How can we best help?			
What are your ideas about toilet training?			
How can we best help?			

## 3. Behavior:

Does your child have any special fears?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How does your child communicate his/her needs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any special words that your child uses that might not be readily recognized?			
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?			
When your child gets upset, what helps him/her calm down?			
What is a good way to distract your child when he/she is having a temper tantrum?			
Are there any particular routines that are particularly helpful at naptime?			

What position is most comfortable for your child when he/she is napping?	
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#### 4. Eating Preferences:

What are your child's favorite foods?			
Does your child use utensils, eat with fingers, feed self?			
Does your child choke easily while eating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

#### 5. Activities:

What activities do you like to do with your child?			
What activities does your child like to do when playing with other children?			
What does your child like to do when he is playing alone?			

#### 6. Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)	
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I verify that the above assessment was discussed with the parent(s) of \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Director Date Signed

I verify that the director appropriately relayed the information concerning my child's assessment.

\_\_\_\_\_  
Signature of Parent Date Signed

#### Additional Comments:

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