

## 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:		Director's Name:	
Child's Full Name:		Child's Date of Birth:	Child Lives With? <input type="radio"/> Both parents <input type="radio"/> Mom <input type="radio"/> Dad <input type="radio"/> Guardian
Child's Home Address:		Date of Admission:	Date of Withdrawal:
Name of Parent/Guardian 1:	Parent/Guardian 1 Phone Number:	Address of Parent/Guardian (if different from the child's):	
Name of Parent/Guardian 2:	Parent/Guardian 2 Phone Number:	Address of Parent/Guardian (if different from the child's):	
Are there Custody Documents on File? <i>Custody Documents establish who has legal authority over and duty to care for a child (typical in cases of divorce, foster care, adoption, etc.).</i> <input type="radio"/> Yes <input type="radio"/> No			
<b>In case of an emergency, call:</b>			
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:
Address:			
I would also like to authorize the child care operation to release my child to leave the child care operation to the emergency contact listed above. <input type="radio"/> Yes <input type="radio"/> No			
<b>Authorized Pickups (NOT parent/guardian):</b> I authorize the child care operation to release my child to leave the child care operation ONLY with the following persons. Please list name, relationship, and phone number for each. Children will only be release to a parent or guardian or to a person designated by the parent or guardian after verification of ID.			
Name (must be local to BCS):		Relationship:	Area Code and Phone No.:
Name:		Relationship:	Area Code and Phone No.:
Name:		Relationship:	Area Code and Phone No.:

### Consent Information

#### 1. Transportation:

I give consent for my child to be transported and supervised by the operation's employees (Check all that apply).

for emergency care    on field trips    to and from home    to and from school

#### 2. Field Trips (see handbook for additional guidance on 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:

**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 wading pools    swimming pools    aquatic playgrounds

Is your child able to swim without assistance?

- Yes    No

Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming?

- 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 operational policies, including those for (Check all that apply).

- |  |  |
|--|--|
| <input type="checkbox"/> Discipline and guidance   | <input type="checkbox"/> Procedures for release of children  |
| <input type="checkbox"/> Suspension and expulsion  | <input type="checkbox"/> Illness and exclusion criteria  |
| <input type="checkbox"/> Emergency plans   | <input type="checkbox"/> Procedures for dispensing medications   |
| <input type="checkbox"/> Procedures for conducting health checks   | <input type="checkbox"/> Immunization requirements for children  |
| <input type="checkbox"/> Safe sleep  | <input type="checkbox"/> Meals and food service practices  |
| <input type="checkbox"/> Procedures for parents to discuss concerns with the director  | <input type="checkbox"/> Procedures to visit the center without securing prior approval  |
| <input type="checkbox"/> Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions | <input type="checkbox"/> Procedures for supporting inclusive services  |
| <input type="checkbox"/> Procedures for parents to participate in operation activities                                       | <input type="checkbox"/> Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline, and CCR website |

**5. Meals:**

I understand that the following meals will be served to my child while 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.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

**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.

\_\_\_\_\_  
Signature — Parent or Legal Guardian

\_\_\_\_\_  
Date Signed

8. Child's Special Care Needs (check all that apply)	
<input type="checkbox"/> Environmental allergies	<input type="checkbox"/> Limitations or restrictions on child's activities
<input type="checkbox"/> Food intolerances	<input type="checkbox"/> Reasonable accommodations or modifications
<input type="checkbox"/> Existing illness	<input type="checkbox"/> Adaptive equipment ( <i>include instructions below</i> )
<input type="checkbox"/> Previous serious illness	<input type="checkbox"/> Symptoms or indications of potential complications related to a physical, cognitive, or mental condition that may warrant prevention or intervention while the child is in care
<input type="checkbox"/> Injuries and hospitalizations ( <i>past 12 months</i> )	<input type="checkbox"/> Medications prescribed for continuous long-term use
<input type="checkbox"/> Other: _____	

Explain any needs selected above:

Does your child have an Individualized Education Plan (IEP), an Individualized Family Service Plan (IFSP) or any other related documents?  Yes  No Plan Submitted Date: \_\_\_\_\_

Does your child have diagnosed food allergies?  Yes  No Food Allergy Emergency Plan Submitted Date: \_\_\_\_\_

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit <https://www.ada.gov/resources/child-care-centers/>. 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 Signed

**9. School Age Children – Only necessary for summer programs.**

**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	Phone No.
Name of Emergency Care Facility	Address	Phone No.

**EMERGENCY CARE FACILITIES**

**BRYAN, TX Facilities**

**CapRock Hospital**, ph. 979.314.2323  
134 Briarcrest Drive | Bryan, TX 77802

**Physicians Premier ER**, ph. 979.775.0911  
2411 Boonville Road | Bryan, TX 77808

**St. Joseph Health Regional Hospital**, ph. 979.776.3777  
2801 Franciscan Dr. | Bryan, TX 77802

**COLLEGE STATION, TX Facilities**

**Baylor Scott & White Medical Center**, ph. 979.207.0100  
700 Scott & White Drive | College Station, TX 77845

**CapRock 24HR Emergency Care**, ph. 979.314.2323  
948 William D. Fitch Parkway | College Station, TX 77845

**St. Joseph Health College Station Hospital**, ph. 979.764.5100  
1604 Rock Prairie Rd. | College Station, TX 77845

**SignatureCare ER**, ph. 979.213.5728  
1512 Texas Ave S, Suite 500 | College Station, TX 77840

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

### 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 or member of.

### Vision Exam Results (4 years & up ONLY)

Right Eye 20/      Left Eye 20/       Pass       Fail

\_\_\_\_\_  
Signature – Health Care Professional

\_\_\_\_\_  
Date Signed

### Hearing Exam Results (4 years & up ONLY)

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				<input type="radio"/> Pass <input type="radio"/> Fail
Left				<input type="radio"/> Pass <input type="radio"/> Fail

\_\_\_\_\_  
Signature – Health Care Professional

\_\_\_\_\_  
Date Signed

### 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. *\*List name and address of Health Care Professional Below.*
- 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. *\*List name and address of Health Care Professional Below.*

*\*Name of Health Care Professional, if selected*

*\*Address of Health Care Professional, if selected*

\_\_\_\_\_  
Signature — Health Care Professional

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature — Parent or Legal Guardian

\_\_\_\_\_  
Date Signed

### Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose. **You can either provide us with a copy of your child's vaccination record OR your child's doctor can fill in the vaccination dates in the table below.**

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.	

#### Physician or Public Health Personnel Verification

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

\_\_\_\_\_  
Signature — Health Care Professional

\_\_\_\_\_  
Date Signed

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

### TB Test (If required)

Positive  Negative    Date: \_\_\_\_\_

**This is NOT required in Brazos County**

### Gang Free 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>

### Signatures

\_\_\_\_\_  
Child's Parent or Legal Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Center Designee

\_\_\_\_\_  
Date Signed