

ADMISSION INFORMATION

Facility Name		Director's Name	
Child's Name		Date of Birth	Child's Home Telephone No.
Child's Address			
Date of Admission	Date of Withdrawal	Hours and days child will be in care	
Parent's or Guardian's Name		Address (if different from child's address)	
List telephone numbers where parents/guardian may be reached while child will be in care:		Mother's Telephone No.	Father's Telephone No.
		Guardian's Telephone No.	
Give name of person to call in case of an emergency if parents / guardian cannot be reached:		Telephone No.	Relationship
I hereby authorize the childcare facility to allow my child to leave the childcare facility ONLY with the following persons. (NAME and PHONE NUMBER)			

CHECK ALL THAT APPLY:

1. **TRANSPORTATION:** I hereby give do not give – my consent for my child to be transported and supervised by facility's employees:
 Check box for emergency care on field trips to and from home to and from school

2. **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

3. **FIELD TRIPS:** I hereby give do not give – my consent for my child to participate in Field Trips:
Parent's Comments :

4. **RECEIPT OF WRITTEN OPERATIONAL POLICIES.**
 I acknowledge receipt of the operational policies including those for discipline and guidance.

Signature - Parent or Legal Guardian

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 immunizations and tuberculosis test are current. Current Vision and Hearing screening records are also on file.

My child has permission to ride a bus, walk to and from school, and/or be released to the care of his/her sibling(s) under 18 years old.

Name of sibling(s): _____

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

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the person in charge to take my child to:		
Name of Physician:	Address :	Ph.# :
Name of Hospital :	Address :	Ph.# :
I give consent for this facility to secure any and all necessary emergency medical care for my child.		
_____ Signature - Parent or Legal Guardian		

HEALTH REQUIREMENTS

Name of Child:				Date of Birth :	
IMMUNIZATIONS	Date / dose 1	Date / dose 2	Date / dose 3	Date / booster	Date / booster
DTP / DTaP / DT					
POLIO IPV or OPV					
MEASLES Rubeola / Serampion					
MUMPS					
RUBELLA					
Hib					
Hepatitis A					
Hepatitis B					
TB TEST (if required)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date :		
Varicella (see below)					
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	

Signature of Health Care Professional _____ Date _____

Signature of staff making handwritten copy of record _____ Date _____

ADMISSION REQUIREMENT: One of the following must be presented when your child (under the age of 5 years) is admitted to the day care facility or within one week of admission. Check to indicate the option you select:	
<input type="checkbox"/> HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he / she is physically able to take part in the day care program.	
_____	_____
Health Care Professional's Signature Date	
<input type="checkbox"/> A copy of the medical screening form of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, if no referral for further diagnosis and treatment is indicated.	
<input type="checkbox"/> A form or written statement from a health service or clinic.	
If you do not have any of the above:	
<input type="checkbox"/> PARENT'S STATEMENT: My child has been examined within the past year by a health care professional and is able to participate in the day care program:	
Name and address of health care professional:	
<input type="checkbox"/> Within 12 months of admission, I will obtain a health care professional's statement and will submit it to the day care facility.	
OR	
<input type="checkbox"/> My child has an appointment for a physical examination:	
Date:	Name and Address of health care professional:
_____	_____
I will submit the statement, from a health care professional to the child-care facility following the examination.	

Signature - Parent or Legal Guardian Date	

HEARING	DATE	SIGNATURE		
Hz	1000	2000	4000	PASS <input type="checkbox"/>
R				
L				FAIL <input type="checkbox"/>
VISION	DATE	SIGNATURE		
R20/	L20/			PASS <input type="checkbox"/> FAIL <input type="checkbox"/>

NOTE: If medical diagnosis and treatment and / or immunization and TB testing conflict with your religious beliefs, you must sign an affidavit to that effect and attach it to this form. If immunization and / or TB testing would be injurious to your child or family, you must obtain a certificate (signed by a health care professional) to that effect and attach it to this form.