ADMISSION INFORMATION

Operation Name		Director's Name	
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 **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:

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

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

3. ☐ 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

4. ☐ 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:
☐ **None** ☐ **Breakfast** ☐ **AM Snack** ☐ **Lunch** ☐ **PM Snack** ☐ **Supper** ☐ **Evening Snack**

6. MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:

☐ Mondays	from:	to:
☐ Tuesdays	from:	to:
☐ Wednesdays	from:	to:
☐ Thursdays	from:	to:
☐ Fridays	from:	to:
☐ Saturdays	from:	to:
☐ Sundays	from:	to:

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:	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

ADMISSION INFORMATION

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.

Name of sibling(s):

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

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

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL
SIGNATURE _____		DATE _____	

HEARING	**1000 Hz**	**2000 Hz**	**4000 Hz**	☐ PASS ☐ FAIL
R				
L				
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											
Pneumococccal											
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

Signature – Parent or Legal Guardian Date

Child Assessment Form

Form 7293
August 2007

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. 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

Form 7293
August 2007

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

* If applicable.

1. Health

Does your child have any allergies?	☐ Yes	☐ 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?	☐ Yes	☐ No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?	☐ Yes	☐ No
Is your child taking any medication?	☐ Yes	☐ 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?	☐ Yes	☐ No
Are there any side effects we should be alerted to?	☐ Yes	☐ No

2. Toileting:

Does your child need assistance with toileting?	☐ Yes	☐ 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?	☐ Yes	☐ No
How does your child communicate his/her needs?	☐ Yes	☐ 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?		

Child Assessment Form

Form 7293
August 2007

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?		☐ Yes	☐ 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)	

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:

High Achievers Learning Center

Enrollment Date: _____

CHILD INFORMATION CARD

Name of Child: _____ DOB:_____ Sex of Child:_____

Home Address: _____

Home Phone: _____ Mobile Phone: _____

Parent or Guardian: _____ Driver's License #:_____

Employer: _____ Work Address: _____

Work Phone: _____ Email Address: _____

Emergency contact in case parents/guardian cannot be reached:

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

Child's Physician: _____

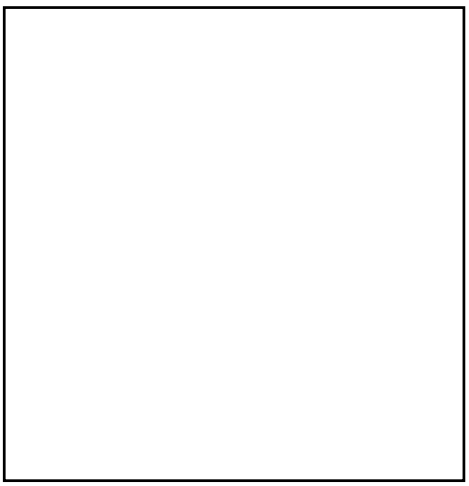
Address: _____

Names of Person authorized to pick up child

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

Child's Photo



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME: _____ CASE NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and case number: NAME: _____ CASE NUMBER: _____

Check here if no case number ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _ _ _ - _ _ - _ _ _ _ ☐ I do not have a Social Security Number

WIC: The Special Supplemental Nutrition Program for Woman, Infants, and Children

1. What is WIC?

WIC is a nutrition program for woman, infants and children. It teaches young families how to stay healthy through better nutrition and how to stretch a tight food budget. It also provides supplemental foods and helps family's access health and medical services. Some WIC clinics also provide childhood immunizations, and others can refer families to the nearest shot clinic. WIC educates woman about the benefits of breastfeeding, and offers guidance and support to breastfeeding women.

1. Who is eligible?

Pregnant, postpartum and breastfeeding women, infants, and children up to age 5 are eligible. They must meet income guidelines, a State residency requirement, and be individually determined to be at "nutritional risk" by a health professional.

To be eligible on the basis of income, applicants' gross income (i.e. before taxes are withheld) must fall at or below 185 percent of the U.S. Poverty Income Guidelines.

Income Eligibility Guidelines (effective 07/01/13 - 06/30/14)			
	Annually	**Monthly**	**Weekly**
Family of 1	$21,257	$1,772	$409
Family of 2	28,694	2,392	552
Family of 3	36,131	3,011	695
Family of 4	43,568	3,631	838
Family of 5	51,005	4,251	981
Family of 6	58,442	4,871	1,124
Family of 7	65,879	5,490	1,267
Family of 8	73,316	6,110	1,410
For each additional family member, add	+ $7,437	+ 620	+ 144

Permission to Photograph

I, _____ give permission for High Achievers Learning Center to

Photograph my child, _____ for the following purposes:

(Please Check One)

TYPE OF USE:	Grant Permission	Decline Permission
Still Photographs:		
Display in my personal Scrapbook		
Give Photographs possibly containing your child to clients		
Display in facility's scrapbook or bulletin boards, shown to current and prospective clients		
Display still photos on my daycare website		
Videos:		
Give Video to current parents		
Other (Please List)		

*Only first names and possibly last initials (in the event of two more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my Childs's enrollment.

Signature: _____ Date: _____

(Parent or guardian signature)