Admission Information

Operation Name Rainbow Corner Preschool	Director's Name Karen Lubbe	Date of Admission
Child's Full Name	Child's Date of Birth	Child's Home Phone Number
Child's Home Address		
Parent(s) or Guardian(s) Names	Address (if different from child's address)	
Mother's Email Address	Father's Email Address	
List phone numbers below where parents/guardians may be reached while child will be in care		
Mother's Cell Phone / Mother's Work Phone	Father's Cell Phone	Father's Work Phone
Name and Address of person to call in case of an **emergency** if parents cannot be reached	Phone Number	Relationship
I hereby authorize the childcare operation to allow my child to leave the childcare operation ONLY with the following persons. Please list name & phone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.		
Name & Phone Number	Name & Phone Number	
Name & Phone Number	Name & Phone Number	
Name & Phone Number	Name & Phone Number	

FIELD TRIP:

I hereby ☐ give ☐ do not give consent for my child to participate in a field trip to the pumpkin patch onsite at Grace Avenue United Methodist Church.

SNACKS:

☐ I understand that a morning snack will be served to my child while in care.

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

☐ Mondays from 9:15-2:10 ☐ Tuesdays from 9:15-2:10 ☐ Wednesdays from 9:15-2:10 ☐ Thursdays from 9:15-2:10

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:	Phone Number:
Emergency Medical Care Facility (do **not** put 'closest'):	Address:	Phone Number:

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature of Parent or Legal Guardian:

HEALTH CONCERNS:

Does your child have any diagnosed allergies? ☐ no ☐ yes (If yes, list the allergies below and **you must attach an allergy action plan signed by your doctor)**

List any health concerns, 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 caregivers should be aware of:

_____

_____

_____ _____

Signature of Parent or Legal Guardian Date

Child's Name_____

Immunization Record (please check one)

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

☐ 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

Health Statement: One of the following must be presented when your child is admitted to the child-care operation within one week of admission.
Please check only one option:

☐ Health-Care Professional's Statement: I have examined the child within the past year and find that he/she is able to take part in the child care program.

_____ _____
Health Care Professional's Signature Date

☐ 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 the following health care professional and is able to participate in the day care program. I will obtain a health care professional's signed statement and will submit it to the child-care operation, within 12 months.

_____
Name and Address of Health Care Professional

_____ _____
Signature of Parent or Legal Guardian Date

Hearing and Vision Screenings (required for any child that is 4 by September 1 of the current year)

Hearing	1000 Hz	2000 Hz	4000 Hz	☐ PASS ☐ FAIL
Right				
Left				
Signature of Health Care Professional			Date	
Vision	Right 20/_____	Left 20/_____		☐ PASS ☐ FAIL
Signature of Health Care Professional			Date	

_____ _____
Signature of Parent or Legal Guardian Date

*The fax number for Rainbow Corner is (469) 305-3130 if you would like to have your doctor's office fax this form to us.