

* = Required Information

Child's Full Name* Gender Male Female

Child's Date Birth* Child's Home Telephone*

Child's Home Address*

Date of Admission Date of Withdrawal

Parent's or Guardian Name* Address (if different from child's address)*

List telephone numbers below where parents/guardian may be reached while the child will be in care:

Mother's Telephone No.

Father's Telephone No.

Guardian's Telephone No.

Cellphone No.

Give the name, address and phone number of person to call in case of 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 person. Please list name & telephone number for each. Children will only be release to a parent or a person designated by the parent/guardian after verification ID.

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 medical 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) of (800) 514-0383 (TTY).

School Age Children

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:

ride a bus, walk to or from school be released to the care of his/her sibling(s)

and/or

or

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 years and find that he/she is able to take part in the day care program.

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:

Vision

R 20/

L 20/

PASS FAIL

HEARING	1000 Hz	2000 Hz	4000 Hz	<input type="checkbox"/> PASS	<input type="checkbox"/> FAIL
R	<input type="text"/>	<input type="text"/>	<input type="text"/>		
L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> PASS	<input type="checkbox"/> FAIL

HEALTH REQUIREMENTS											
Age	1	2	4	6	12	15	18	19-23	2-3	4-6	
Vaccine	birth	mos	mos	mos	mos	mos	mos	mos	mos	Yrs	Yrs
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotavirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria, tetanus, pertussis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haemophilus influenzae type b	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inactivated Poliovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenzae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measles, Mumps, Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meningococcal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TB TEST (if require) Positive Negative Date:

Security Code*

63698