



A Kindergarten Readiness Program 18 months -- Pre-K

512-629-3014

Smithville Church of Christ

Child's Full Name: _____ Birth Date: _____

Address: _____ Home Phone: (____) _____

City: _____ State: _____ Zip Code: _____

Nickname: _____

Mother's Full Name: _____ Home Phone: (____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Work Phone: (____) _____ ext. _____

Name of Employer: _____ Pager or Cellular Phone: (____) _____

Business Address: _____ City: _____

Work Hours: _____

Father's Full Name: _____ Home Phone: (____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Work Phone: (____) _____ ext. _____

Name of Employer: _____ Pager or Cellular Phone: _____

Business Address: _____ City: _____

Work Hours: _____

Parent/Guardian with legal custody _____

Parents are: Married ___ Living Together ___ Divorced ___ Separated ___ Widowed ___ Single



Other Household Members:

Names: _____ Ages: _____ Relationships _____

Emergency Contacts

(Within 20 mile radius of daycare other than parent or guardian)

Primary Emergency Contact (other than parents or guardian)

Home Phone: _____ Work Phone: _____

Relationship to Child: _____

Address: _____

Secondary Emergency Contact (other than parents or guardian)

Home Phone: _____ Work Phone: _____

Relationship to Child: _____

Address: _____

Person (s) authorized to pick up my child: (Besides parents, guardians, or emergency pick ups)

Name: _____ Comment _____

Kid Code: _____ (Secret word between parent & child for identification and pick up)

Person (s) NOT authorized to pick up my child: (Besides parents, guardians, or emergency pick ups)

Name: _____ Comment _____



Emergency Release

Consent to Emergency First Aid & Transportation:

I hereby give permission that my child, _____, may be given emergency treatment by a staff member at _____ Childcare. I also give permission for my child to be transported by car, ambulance, or Air car to an emergency center for treatment, and agree to hold _____ and its employees harmless.

Parent's Signature _____ Date: _____

Consent to Medical Care and Treatment:

In the event that I cannot be contacted immediately, medical or surgical treatment can be administered to my child in the case of an accident or emergency, as prescribed by a treating physician, and hold _____ Childcare and its employees harmless.

Parent's Signature _____ Date _____



Emergency Information

1. Child's Physician: _____ Phone: () _____

2. Preferred Hospital: _____ Phone: () _____

3. Insurance Company: _____ Policy #: _____

4. Regular Medications: _____

5. Blood Type: _____

6. Medicine allergic to: _____

7. Food Allergies: _____

8. Any other Allergies: _____

9. Any special health conditions: _____



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													
Pneumococcal													
Inactivated Poliovirus													
Influenza													
Measles, Mumps, Rubella													
Varicella													
Hepatitis A													
Meningococcal													
TB TEST (if required)		<input type="checkbox"/> Positive		<input type="checkbox"/> 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	
<input type="checkbox"/> 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 http://www.dshs.state.tx.us/immunize/school_info.htm													

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:

- 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
- 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 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/ _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE _____		DATE _____	
HEARING	1000 Hz	2000 Hz	4000 Hz
R			
L			
SIGNATURE _____		DATE _____	

Signature - Parent or Legal Guardian Date



EMERGENCY - PERMISSION CARD

Providers Name: _____ Date: _____
 Address: _____

Child's Photo	Child's Name: _____ Hair Color: _____ Eye Color: _____ Birth date: _____ Address: _____ Home Phone: _____
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Mother's Name: _____ Work Phone: _____
 Father's Name: _____ Work Phone: _____
 Mothers Home Phone: _____ Father's Home Phone: _____
 Emergency Contact: _____ Phone: _____
 Address: _____
 Child's Doctor: _____ Phone: _____
 Child's Health # _____ ID# _____
 Allergies: _____
 Medication: _____
 Medical Condition: _____
 Child's Dentist: _____ Phone: _____

It is the child care provider's policy to notify a parent when a child is ill or in need of medical attention. Occasionally we are unable to contact parents, and we need to get immediate help for the child.

Our procedure is to have the child taken to the nearest emergency service by ambulance. (Ambulance fee is the parent's responsibility.)

If an ambulance is not available, the child care provider/staff of the child care will transport the child

I hereby give permission to the child care provider/staff of _____ to make necessary transportation arrangements for my child _____ who has become ill or injured.

(name of child)

_____ Signature of parent/guardian	_____ Signature of parent/guardian
_____ Date	_____ Signature of provider

Print on card stock. Fold on center line and glue. Keep one for each child in your first aid kit. Remember to take on field trips and outings.



AUTHORIZATION FOR EMERGENCY MEDICAL CARE
AUTORIZACION PARA ATENCION MEDICA DE EMERGENCIA

If I cannot be reached to make arrangements for
emergency medical care for my child at the time of an
illness or accident, I give my permission for:

Si en caso de alguna enfermedad o accidente no me pueden
localizar para arreglar atención médica de emergencia para
mi niño, doy permiso para que:

Name of Day Care Facility Owner or Director Nombre del Dueño o Director del Centro de Cuidado de Niños

to take my child (or children):

a que lleve a mi niño (o mis niños):

Name of Child (1)/Nombre del Niño (1)	Name of Child (2)/Nombre del Niño (2)
Name of Child (3)/Nombre del Niño (3)	Name of Child (4)/Nombre del Niño (4)

to:

at:

Name of Doctor/Nombre del Doctor	Telephone No./Teléfono
Address of Doctor/Dirección del Doctor	

or to:

o at:

Name of Hospital or Clinic/Nombre del Hospital o Clínica	Telephone No./Teléfono
Address of Hospital or Clinic/Dirección del Hospital o Clínica	

I give consent for necessary emergency treatment
when my child is in the care of this physician or
hospital or clinic.

Doy mi consentimiento para el tratamiento médico
necesario estando mi niño bajo la atención de este
doctor u hospital o clínica.

Signature-Parent or Legal Guardian
Firma-Padre o Tutor

Date/Fecha

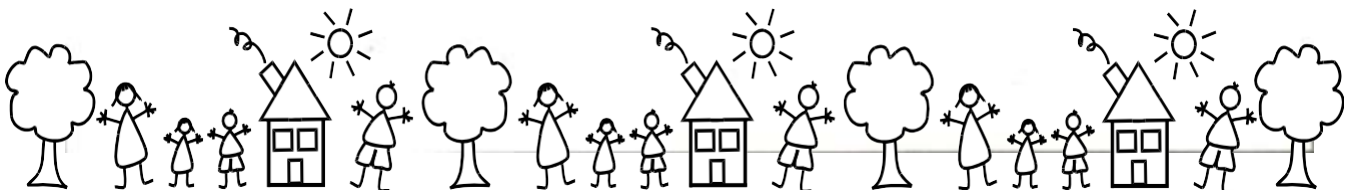


Photo Release

Providers name: _____

Child's full name: _____

Photographs and videos are taken on some occasions such as birthdays, holidays, outings and special occasions. We use these pictures/videos in our child care home for teaching, arts & crafts, albums and various other things.

Please mark the appropriate box:

I give permission I do not give permission
for photos to be taken

Please mark the appropriate box:

I give permission I do not give permission
for videos to be taken

Cute photos are taken during the day of your children doing the most awesome activities and we post them on the Preschool Facebook page for you and your family to see. 😊

I understand that these photographs and/or videos will not be sold, distributed or placed on internet web sites without my written permission.

Date: _____

Parent Signature: _____

Provider's Signature: _____



OTC Medication Form

(Over The Counter Medicine Form)

Child's Name: _____ Date _____

I hereby give _____ permission to apply or give one or more of the following over the counter medications or external preparations, in accordance with the directions for use on the container:

- Tylenol*
- Baby Wipes*
- Band-Aids
- Neosporin, Bacitricin, or similar ointment
- Bactine or similar first aid spray
- Sunscreen*
- Insect Repellent*
- Non-Prescription Ointment (Such as A & D, Desitin, Vaseline)*
- Powder*
- Baby Lotion*
- *Other: (please specify) _____

Specify frequency and duration of use: _____

Special Instructions: _____

(Note: If the instructions for administering the medication, cream, etc. are not printed on the container (such as with Tylenol for children under 2), then I need a form from the child's doctor indicating the appropriate dosage to be given.)

I hereby request that _____ administer one or more of the above over the counter medications or external preparations in accordance with the directions on the container as needed. This consent is valid from today until _____ I may withdraw this request at any time.

I release _____ from any liability for administering these preparations.
Parent(s): _____ Date _____



Child Pick-Up Form

A. The following people **HAVE** permission to pick-up the child named below from the daycare home of _____ . It is the parent's responsibility to notify me in writing of any changes.

Child's Name	DOB	Age	Sex
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1. Name: _____ DL #: _____
Relationship: _____
Address: _____
Phone: _____

2. Name: _____ DL #: _____
Relationship: _____
Address: _____
Phone: _____

3. Name: _____ DL #: _____
Relationship: _____
Address: _____
Phone: _____

B. The following people **MAY NOT** pick-up my child(ren) from _____

1. Name: _____ DL #: _____
Relationship: _____
Address: _____
Phone: _____



2. Name: _____ DL #: _____

Relationship: _____

Address: _____

Phone: _____

Note: Any person unfamiliar to me will be required to show proof of identification. Under NO circumstances will the child be released to anyone other than those listed above without WRITTEN permission from the parent.

This form is legally binding, so by signing it, you agree that all of the information provided herein is correct. False Information will result in termination of contract, and you will forfeit your childcare retainer.

Father/Guardian's Signature	Date
Mother/Guardian's Signature	Date
Provider name/daycare name	Date

All God's Children Preschool



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