

IABC ADMISSION INFORMATION

Operation Name IABC: <input type="checkbox"/> PDO <input type="checkbox"/> Preschool		Director's Name Bianca Foley		Date of Admission	Date of Withdrawal
Child's Full Name Male/Female			Child's Date of Birth	Age Group: <input type="checkbox"/> PDO- Infants (<1yr) <input type="checkbox"/> PDO - 1s <input type="checkbox"/> PDO - 2s <input type="checkbox"/> PK- 3s <input type="checkbox"/> PK 4s	
Child's Home Address			Home Telephone Number:		
Parent(s) or Guardian(s) Name(s)		Address (if different from child's address)			
Mother's Cell Phone	Mother's Work Phone		Mother's Email Address		
Father's Cell Phone	Father's Work Phone		Father's Email Address		
Give the name, relationship, address and phone number of a person to call in case of emergency if parent/guardian cannot be reached.					
Name:		Address:		Phone Number:	
Relationship:					
I hereby authorize the childcare operation to allow my child to leave the childcare operation with the following persons other than parent(s)/guardian(s). Children will only be released after verification of id.					
1. Name: _____		Phone Number: _____			
2. Name: _____		Phone Number: _____			
3. Name: _____		Phone Number: _____			

CHECK ALL THAT APPLY:

Emergency TRANSPORTATION: I hereby give do not give consent for my child to be transported and supervised by IABC employees in an emergency situation.

PK FIELD TRIPS: I hereby give do not give consent for my child to be transported, supervised by IABC employees and participate in Field Trips.

WATER ACTIVITIES: I hereby give do not give consent for my child to participate in water activities Sprinkler Play splashing/wade pools water table

The following meals will be served to my child while in care: None AM Snack Lunch – parent provided

1. My Child will normally be in care on the following Days and Times:

PDO – 2:30 /Preschool- 12:00 or 2:30 for each day			Early Drop Off 8:30-9:00
<input type="checkbox"/> Mondays	from: 9:00	till: 12:00 or 2:45	<input type="checkbox"/> Mondays
<input type="checkbox"/> Tuesdays	from: 9:00	till: 12:00 or 2:45	<input type="checkbox"/> Tuesdays
<input type="checkbox"/> Wednesdays	from: 9:00	till: 12:00 or 2:45	<input type="checkbox"/> Wednesdays
<input type="checkbox"/> Thursdays	from: 9:00	till: 12:00 or 2:45	<input type="checkbox"/> Thursdays

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event I cannot be reached to make arrangements for medical care, I authorize the person in charge to take my child to:

Physician Care Preference

Name of Physician:	Address	Phone Number
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Emergency Care Preference (Choose One)

- | | | |
|---|---|------------------------------|
| <input type="checkbox"/> Star ER (closest) | Address: 7007 Indiana Ave, Lubbock, TX 79413 | Phone Number: (806) 701-4141 |
| <input type="checkbox"/> Covenant Children's ER | Address: 4000 24 th Street Lubbock TX, 79410 | Phone Number: (806) 725-0000 |
| <input type="checkbox"/> University Medical Center ER | Address: 602 Indiana Ave, Lubbock, TX 79415 | Phone Number: (806) 775-8200 |
| <input type="checkbox"/> Other: | | |

Name:	Address:	Phone Number:
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I give consent for the facility to secure any and all necessary emergency care for my child.

Parent/Guardian Signature: _____

List any problems your child may have such as allergies, existing illness, previous serious injury, injuries and hospitalizations during the past 12 months, any medication prescribed for long-time continuous use and nay other information a caregiver should be made aware of:

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA) tile III, If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA information line (800)514-0301 (voice) or (800)514-0383 (TTY).

Signature – Parent /Guardian: _____ **Date:** _____

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IMMUNIZATION RECORD: I have provided the childcare operation with a current immunization record.

ADMISSION REQUIREMENT – PHYSICIAN STATEMENT: One of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

Health Care Professional Statement: I have examined _____ 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 separate signed and dated health care professionals statement, similar to above.
- Medical diagnosis and treatment conflict: including tenets and practices of a recognized religious organization, which I adhere to or am a member of; (A signed and dated affidavit stating above exemption is required.)
- Parent 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. Within 12 months of admission, I will obtain a health care professional's statement and will submit it to the child-care operation.

Name of Child Care Professional: _____

Address of Child Care Professional: _____

Initials _____

Written Operational Policies

I have received a copy of Operational Policies

I acknowledge receipt of the facilities operational policies, including those for:

<input checked="" type="checkbox"/> Discipline and Guidance	<input checked="" type="checkbox"/> Procedures for Release of Children
<input checked="" type="checkbox"/> Suspension and Expulsion	<input checked="" type="checkbox"/> Illness and Exclusion Criteria
<input checked="" type="checkbox"/> Emergency Plans	<input checked="" type="checkbox"/> Procedures for Dispensing Medication
<input checked="" type="checkbox"/> Procedures for Conducting Health Checks	<input checked="" type="checkbox"/> Immunization Requirements for Children
<input checked="" type="checkbox"/> Safe Sleep (if under 12 months of age)	<input checked="" type="checkbox"/> Meals and Food Service Practices
<input checked="" type="checkbox"/> Procedures for Parents to discuss concerns w/Director	<input checked="" type="checkbox"/> Procedures to visit center without prior approval
<input checked="" type="checkbox"/> Procedure for Parents to participate in center activities	<input checked="" type="checkbox"/> Procedures to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website.

Custody

Child lives with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Guardian
Custody Documents On File: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable

Special Accommodations

Does your child have doctor diagnosed food allergies? Yes No (If Yes, an Allergy Plan is required.)
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Signatures

Parent/Guardian Signature: _____ **Date:** _____

Printed name of Parent/Guardian Completing Form: _____

Center Designee Signature: _____ **Date:** _____

Gang Free Zone – Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gong-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement – DFPS values your privacy. For more information, read our Privacy and Security Policy online at <http://www.dfps.state.tx.us/policies/privacy.asp>.