ENROLLMENT INFORMATION

Operation Name: Petra Preschool	**Director's Name: Mindy Lee**
Child's Full Name:	Child's Date of Birth:
Child's Home Address:	
Date of Admission:	Date of Withdrawal:

Mother's Name:	Father's Name:	Guardian's Name:
List telephone numbers below where parents/guardian may be reached while the child is in care:		
Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.
Mother's Address:	Father's Address:	Guardian's Address:
Mother's Email:	Father's Email:	Guardian's Email:

In case of an emergency if parents/guardian cannot be reached:			
Name:	Address:	Phone No.	Relationship:
Name:	Address:	Phone No.	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 photo ID.	
Full Name:	Telephone No.
Full Name:	Telephone No.
Full Name:	Telephone No.

How did you hear about Petra Preschool?	
☐ Social Media	☐ Ad
☐ Newsletter	☐ Event
☐ Friends/Family	☐ Other:

______________________________ Signature – Parent or Legal Guardian

______________________________ Date

ENROLLMENT INFORMATION

CHECK ALL THAT APPLY:		
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:

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 caregivers should be aware of:

____

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____

____

Signature – Parent or Legal Guardian Date

ENROLLMENT INFORMATION

IMMUNIZATION RECORD:

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

ADMISSION REQUIREMENT: 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 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. ☐ 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:

___________________________ ____________________________

Name Address

_______________________________________ ____________________

Signature – Parent or Legal Guardian Date

VISION	R 20/ ________	L 20/ ________	☐PASS ☐ FAIL
SIGNATURE_______________________________		DATE_______________________________	

HEARING	**1000 Hz**	**2000 Hz**	**4000 Hz**	
R				☐PASS ☐ FAIL
L				
SIGNATURE_______________________________		DATE_______________________________		

_______________________________________ ____________________

Signature – Parent or Legal Guardian Date

ENROLLMENT 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											
Diptheria, Tetanus, Pertussis											
Haemophilus influenzae type b											
Pneumococccal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningocaccal											
TB TEST (if required)	☐ Positive				☐ Negative				Date:		

Signature or stamp of a physician or public health personnel verifying immunization information above.

____ ____________________

Signature or stamp of a physician or public health 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.

____ ____________________

Signature – Parent or Legal Guardian Date

For additional information regarding immunizations contact the Department of State Health Services at www.dshs.state.tx/immunize/public.shtm

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Signature – Parent or Legal Guardian Date