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| Operation Name DR. JOHNS SPORTS CENTER | | Director's Name JOHN KRAMPITZ | |
| Child's Name | | Date of Birth | Child's Home Telephone No. |
| Child's Home Address | | | |
| Date of Admission | Date of Withdrawal | Hours and days child will be in care | |
| Parent's or Guardian's Name | | Address (if different from child's address) | |
| List telephone numbers where parents/guardian may be reached while child will be in care: | Mother's Telephone No. | Father's Telephone No. | Guardian's Telephone No. |
| Give the name, address and phone number of person to call in case of an 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 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 ID. | | | |
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| CHECK ALL THAT APPLY: | | | |
| 1. <input type="checkbox"/> TRANSPORTATION: I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give – consent for my child to be transported and supervised by the operation's employees: <input type="checkbox"/> Check box for emergency care <input type="checkbox"/> on field trips <input type="checkbox"/> to and from home <input type="checkbox"/> to and from school | | | |
| 2. <input type="checkbox"/> FIELD TRIPS: I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give – my consent for my child to participate in Field Trips: Parent's Comments: | | | |
| 3. <input type="checkbox"/> WATER ACTIVITIES: I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give – my consent for my child to participate in Water Activities: <input type="checkbox"/> sprinkler play <input type="checkbox"/> splashing/wading pools <input type="checkbox"/> swimming pools <input type="checkbox"/> water table play | | | |
| 4. <input type="checkbox"/> RECEIPT OF WRITTEN OPERATIONAL POLICIES. I acknowledge receipt of the facility's operational policies including those for discipline and guidance. | | | |

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| 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 caregiver's should be aware of:

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| SCHOOL AGE CHILDREN: | |
| <input type="checkbox"/> My child attends the following school: | |
| Name of School and Address | School Ph.# |
| CHECK ALL THAT APPLY: | |
| <input type="checkbox"/> 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. | <input type="checkbox"/> My child has permission to <input type="checkbox"/> ride a bus, <input type="checkbox"/> walk to and from school, and/or <input type="checkbox"/> be released to the care of his/her sibling(s) under 18 years old. Name of sibling(s): |

Signature – Parent or Legal Guardian

Date

ADMISSION INFORMATION

| HEALTH REQUIREMENTS | | | | | |
|--------------------------------|-----------------------------------|-----------------------------------|---------------|----------------|----------------|
| Name of Child: | | | | Date of Birth: | |
| IMMUNIZATIONS | Date / dose 1 | Date / dose 2 | Date / dose 3 | Date / dose 4 | Date / booster |
| DTP / DTaP / DT | | | | | |
| POLIO IPV or OPV | | | | | |
| MEASLES Rubeola / Serampion | | | | | |
| MUMPS | | | | | |
| RUBELLA | | | | | |
| Hib | | | | | |
| Hepatitis A | | | | | |
| Hepatitis B | | | | | |
| TB TEST (if required) | <input type="checkbox"/> Positive | <input type="checkbox"/> Negative | Date: | | |
| Varicella (see below) | | | | | |

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.

_____ Date _____
Parent's signature

Signature of Health Care Professional _____ Date _____
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 physically able to take part in the day care program.

_____ Date _____
Health Care Professional's Signature
- A signed and dated copy of a health care professional's statement is attached.
- PARENT'S 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 signed statement and will submit it to the child-care operation.

Name and address of health care professional:

 _____ Date _____
 Signature - Parent or Legal Guardian

- 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.

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|-----------------|-------------|-------------|---|
| 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