ADMISSION INFORMATION

Purpose: Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

GENERAL INFORMATION

Operation's Name: Imagination Station	Director's Name: Samantha Beasley	
Child's Full Name:	Child's Date of Birth:	Child Lives With: ☐ Both parents ☐ Mom ☐ Dad ☐ Guardian
Child's Home Address:		
Date of Admission:	Date of Withdrawal:	
Name of Parent or Guardian Completing Form:	Address of Parent or Guardian (if different from the child's):	

List telephone numbers below where parents/guardian may be reached while child is in care.

Parent 1 Telephone No.	Parent 2 Telephone No.	Guardian's Telephone No.	Custody Documents on File: ☐ Yes ☐ No

Give the name, address, and phone number of the responsible individual **to call** in case of an emergency if parents/guardian cannot be reached:	Relationship:

I authorize the child care operation **to release** my child to leave the child care operation **ONLY** with the following persons. Please list name and telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID.

Name and Phone Number:	Name and Phone Number:	Name and Phone Number:

CONSENT INFORMATION

CHECK ALL THAT APPLY:

1.TRANSPORTATION

I give consent for my child to be transported and supervised by the operation's employees:

☒ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2.FIELD TRIPS

☐ I give consent for my child to participate in field trips.

☒ I **do not** give consent for my child to participate in field trips.

Comments:

3.WATER ACTIVITIES

I give consent for my child to participate in the following water activities:

☒ water table play ☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ aquatic playgrounds

CONSENT INFORMATION

CHECK ALL THAT APPLY:

4.RECEIPT OF WRITTEN OPERATIONAL POLICIES

I acknowledge receipt of the facility's operational policies, including those for:

☒ Discipline and guidance	☒ Procedures for release of children
☒ Suspension and expulsion	☒ Illness and exclusion criteria
☒ Emergency plans	☒ Procedures for dispensing medications
☒ Procedures for conducting health checks	☒ Immunization requirements for children
☒ Safe sleep	☒ Meals and food service practices
☒ Procedures for parents to discuss concerns with the director	☒ Procedures to visit the center without securing prior approval
☒ Procedures for parents to participate in operation activities	☒ Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website

5. MEALS

I understand that the following meals will be served to my child while in care:

☐ None ☒ Breakfast ☐ Morning snack ☒ Lunch ☒ Afternoon snack ☐ Supper ☐ Evening snack

6. DAYS AND TIMES IN CARE

My child is normally in care on the following days and times:

Day of the Week	AM	PM
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

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:	Phone Number:
Name of Emergency Care Facility:	Address:	Phone Number:

I give consent for the facility to secure any and all necessary emergency medical care for my child.	Signature - Parent or Legal Guardian

CHILD'S ADDITIONAL INFORMATION SECTION

List any special needs that your child may have, such as environmental allergies, food intolerances, 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:

Does your child have diagnosed food allergies? Yes ☐ No ☐ Plan submitted on:

Child day care 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) or (800) 514-0383 (TTY).

Signature - Parent or Legal Guardian:	Date Signed:

SCHOOL AGE CHILDREN

My child attends the following school:

Name of School:	School Phone Number:

My child has permission to (check all that apply):

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his/her sibling under 18 years old

Authorized pick up/drop off locations other than the child's address:

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

Health Care Professional's Signature:	Date Signed:

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 submit it to the child care operation.

Name and Address of Health Care Professional:

Signature - Parent or Legal Guardian:	Date Signed:

REQUIREMENTS FOR EXCLUSION

☐ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

☐ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

VISION EXAM RESULTS

R 20/	L 20/	☐ Pass ☐ Fail
Signature:	Date Signed:	

HEARING EXAM RESULTS

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				☐ Pass ☐ Fail
Left				☐ Pass ☐ Fail
Signature:			Date Signed:	

VACCINE INFORMATION

The following vaccines require multiple doses over time. Please provide the date your child received *each dose*.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose) 1–2 months (second dose) 6–18 months (third dose)	
Rotavirus	2 months (first dose) 4 months (second dose) 6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose) 4 months (second dose) 6 months (third dose) 15–18 months (fourth dose) 4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose) 4 months (second dose) 6 months (third dose) 12–15 months (fourth dose)	

VACCINE INFORMATION

The following vaccines require multiple doses over time. Please provide the date your child received *each dose*.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Pneumococcal	2 months (first dose) 4 months (second dose) 6 months (third dose) 12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose) 4 months (second dose) 6–18 months (third dose) 4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose) 4–6 years (second dose)	
Varicella	12–15 months (first dose) 4–6 years (second dose)	
Hepatitis A	12–23 months (first dose) The second dose should be given 6 to 18 months after the first dose.	

PHYSICIAN OR PUBLIC HEALTH PERSONNEL VERIFICATION

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

Signature :	Date Signed:

VARICELLA (CHICKENPOX)

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 Signed:

ADDITIONAL INFORMATION REGARDING IMMUNIZATIONS

For additional information regarding immunizations, visit the Texas Department of State Health Services' website at www.dshs.state.tx.us/immunize/public.shtm.

TB TEST (IF REQUIRED)		
☐ Positive	☐ Negative	Date:

GANG FREE ZONE
Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-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.

SIGNATURES	
Child's Parent or Legal Guardian: X	Date Signed:
Center Designee: X	Date Signed:

Permission to Photograph

I, _____, Give permission for ***Imagination Station*** to
(Parent or Guardian's name)
Photograph my child, _____, for the following purposes:
(Child's Name)

(Please check one)

Type of Use:	Grant Permission	Decline permission
Still Photographs:		
Display in provider's personal scrapbook		
Give photographs to current clients		
Display in facility's scrapbook or bulletin boards, shown to current and prospective clients		
Display still photos on facility's website**		
Use still photos in promotional materials		
Videos:		
Give video to current parents		
Display video on facility website		
Use videos in promotional materials		
Other (please list)		

** Only first names and possibly last initials (in the event of two or more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form in the event that I no longer with to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Signed:_____ Date:_____
(Parent or Guardian Signature)

Imagination Station

Child Development Center

Transfer of Records

Confidentiality/Distribution

Imagination Station will transfer a copy of the child's record to the Parent/Guardian, or any other person designated upon written request from the Parent/ Guardian, once the child is no longer attending the center.

Confidentiality and Distribution of records:

The information in a child's record is considered privileged and confidential. No one who is not directly related to the care of your child will have access to your child's record without your consent.

As a Parent/Guardian, if you wish to access your child's records please schedule a conference with the Director.

As the Parent/Guardian, you have the right to add information, comments, data, or other pertinent information to your child's record. You also have the right to request deletion or amendment of any information contained in the child's record.

***Remember: Any legal issues MUST be filed with the center concerning custody or related matters. Our center will NOT act upon any situation that doesn't coincide with the law.*

Signed:_____ Date:_____

Sick Child Policies

Effective: January 1, 2011

This daycare is a well child care facility. This means that if your child is not feeling well, for any reason, you will need to find alternate care. Please do not bring your child if he/she has a contagious illness or exhibits any of the following symptoms:

- Fever of **100.0** degrees or above
- Vomiting, in excess of typical infant spit-ups
- Diarrhea
- Conjunctivitis ("Pink Eye")
- Consistent complaints of ear or stomach pain
- Bleeding other than minor cuts and scrapes
- Excessive greenish nasal discharge, indicating possible infection
- Head Lice
- Other_____

In general, if your child is too sick to go outside and play, then your child is too sick to attend childcare. If your child becomes ill during daycare, you will be phoned at work and asked to pick you child up immediately.

If your child has a common cold (slight cough, sneezing, clear runny nose and/or a temperature below **100.0** degrees) your child may attend daycare. However, if your child reaches a point when he/she requires constant attention, will not play, cries continuously, whines and want to be held constantly, then your child will need to stay home.

Any child requiring prescription medications will need to be kept at home for at least 24 hours until no longer contagious, unless accompanies by a signed note from the child's medical practitioner.

Please dispense all medications at home whenever possible for times when this is not possible, a **Medicine Consent Form** must be filled out in order for us to dispense any medication. All prescriptions and over-the-counter medications must be in their original container(s), and prescription must display the pharmacist's label with the doctor's name. In addition, all prescriptions prescribed more than **10 days** ago must be accompanied by a signed note form the child's medical practitioner.

If you have any questions, please feel free to discuss them with me at any time.

Signatures below indicate acknowledgement of receipt of this form and agreement to adhere to these policies.

Signed_____ Date_____
(parent/guardian)

Provider_____***Imagination Station***_____ Date_____

Discipline and Guidance Policy for Imagination Station
Name of Operation

- Discipline must be:
  (1) Individualized and consistent for each child;
  (2) Appropriate to the child's level of understanding; and
  (3) Directed toward teaching the child acceptable behavior and self-control.

- A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:
  (1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
  (2) Reminding a child of behavior expectations daily by using clear, positive statements;
  (3) Redirecting behavior using positive statements; and
  (4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.

- There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:
  (1) Corporal punishment or threats of corporal punishment;
  (2) Punishment associated with food, naps, or toilet training;
  (3) Pinching, shaking, or biting a child;
  (4) Hitting a child with a hand or instrument;
  (5) Putting anything in or on a child's mouth;
  (6) Humiliating, ridiculing, rejecting, or yelling at a child;
  (7) Subjecting a child to harsh, abusive, or profane language;
  (8) Placing a child in a locked or dark room, bathroom, or closet with the door closed; and
  (9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Texas Administrative Code, Title 40, Chapters 746 and 747, Subchapters L, Discipline and Guidance

My signature verifies I have read and received a copy of this discipline and guidance policy.

Signature _____ Date _____

Check one please:

☒ parent ☐ employee/caregiver ☐ household member of child-care home

Texas Dept of Family and Protective Services

Child Assessment Form

Form 7293
November 2012

Child Name (last, first, middle)	Social Security No.*	Enrollment Date	Date of Birth
Street Address (if rural, attach directions)	City	County	Zip
Mailing Address (if different) -- Street or P.O. Box	City	County	Zip
Telephone No. (include A/C)			

* If applicable.

1. Health

Does your child have any allergies?	☐ Yes	☐ No
If so, what allergies does your child have?		
How should we respond if he/she has an allergic reaction?		
Does your child have an existing illness?	☐ Yes	☐ No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?	☐ Yes	☐ No
Is your child taking any medication?	☐ Yes	☐ No
If so, how is the medication administered, and will it need to be administered while he/she is in care?		
Is the medication prescribed for continuous use?	☐ Yes	☐ No
Are there any side effects we should be alerted to?	☐ Yes	☐ No

2. Toileting:

Does your child need assistance with toileting?	☐ Yes	☐ No
How can we best help?		
What are your ideas about toilet training?		
How can we best help?		

3. Behavior:

Does your child have any special fears?	☐ Yes	☐ No
How does your child communicate his/her needs?	☐ Yes	☐ No
Are there any special words that your child uses that might not be readily recognized?		
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?		
When your child gets upset, what helps him/her calm down?		
What is a good way to distract your child when he/she is having a temper tantrum?		
Are there any particular routines that are particularly helpful at naptime?		

Child Assessment Form

What position is most comfortable for your child when he/she is napping?	

4. Eating Preferences:

What are your child's favorite foods?			
Does your child use utensils, eat with fingers, feed self?			
Does your child choke easily while eating?		☐ Yes	☐ No

5. Activities:

What activities do you like to do with your child?	
What activities does your child like to do when playing with other children?	
What does your child like to do when he is playing alone?	

6. Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)	

I verify that the above assessment was discussed with the parent(s) of _____

_____

_____

_____ _____

Signature of Director Date Signed

I verify that the director appropriately relayed the information concerning my child's assessment.

_____ _____

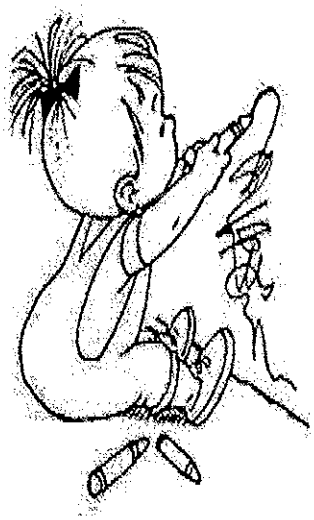
Signature of Parent Date Signed

Additional Comments:

When Your Child Comes Home Messy

Red paint in the hair? Blue paint on the jeans? Sand in the shoes? Peanut butter on the favorite shirt? White socks that look brown? Sleeves a little bit damp?

Your CHILD probably--
Worked with a friend
Solved a problem
Created a masterpiece
Negotiated a difference
Learned a new skill
Had a great time
Developed new language



Your child probably didn't--
Feel lonely
Became bored
Do repetitive tasks that are too babyish
Do worksheet tasks that are too easy
Do sit down work that is discouraging

You probably--
Paid good money for those clothes
Will have trouble getting red paint out
Are concerned that the care giver isn't paying enough attention to you child

THE CARE GIVER probably--
Was aware of your child's needs and interests
Spent time planning a challenging activity for the children
Encouraged the children to try new things
Put smocks on the children
Was worried that you might be concerned

Try to remember your favorite activity when you were four years old. Was it outdoor play with water, med, dress up clothes? Young children really learn when they are actively involved in play, not when someone is talking to them. There is a difference between "messy" and 'lack of care".

The caregiver made sure your child was fed, warm, took a nap, washed hands after toileting and before eating-and planned messy fun things to do, because that's how young children learn!

Send your child in clothes that can get dirty! Keep extra old clothes at the play site for the times when the child gets wet or really messy. If you need to take the child out, bring the dress-up clothes and allow change. Keep calm. Remember, in a few years, teenagers will us shampoo, mirrors and all the towels! But young children need time to be kids. If you have concerns, talk to you child's caregiver about active play.

Infant Sleep Positions

All parents at intake will be given information on sudden infant death syndrome **(SIDS)**. The American Public Heath Association and the American Academy of Pediatrics strongly recommend that infants be put to sleep on their backs to reduce the chance of **(SIDS)**. It is a policy at Imagination Station that all infants will be put to sleep on their backs unless physicians and parents request otherwise. Parents who choose to have their child put to sleep on their side or stomach will need to sign a release statement along with a physician's recommendation, authorizing Imagination Station to make an exception to our policy and releasing Imagination Station from any liability.

Parent authorization statement requested for alternative sleep position:

_____

_____

_____

_____

_____

_____

_____

_____

Parent Signature:_____ Date:_____

Physician's Signature:_____ Date:_____

6 Month Allergy Check-Up

Child:_____ Date:_____
Date of Birth:_____ Expires:_____

Type of milk: Formula/ Soy/ Organic milk/ Whole Milk/ Other_____
Type of juice:_____

Drinking instructions: (include amounts and times)

_____

_____

Foods Allergies-

Feeding Problems:

_____

_____

Allergies to foods:

_____

_____

Skin Allergies-

Allergic reactions:

_____

_____

Special needs:

_____

_____

Parent Signature_____ Date_____

Monthly Feeding Instructions

Baby Name:_____ Month/ Year_____

Bottles: Circle one: Formula / Breast milk Formula Name:_____

How many ounce per feeding?_____ Time between feedings?_____
Would you like us to wake up for feeding times? Yes or No
Would you like us to burp during feeding? Yes or No If yes, how often_____

Juice type:_____ Time to be given:_____

Special Feeding
Instructions_____
_____

Food: Circle one: I will bring or Please provide
Any Allergies or food restrictions: Yes or No If yes, list_____
Feed before or after bottle? _____
Baby cereal name:_____ Mixed with? Water/ Formula/Baby food

Breakfast Time:_____ To be Fed: Cereal/Fruit/Other:_____
Lunch Time: _____ To be Fed: _____
Snack Time: _____ To be Fed: _____

Additional Information:

Does you child use a pacifier? Yes or No If yes, What type?_____

Diaper Ointment Brand:_____ Apply how Often? _____

Skin Allergies:_____

Parent Signature:_____ **Date:**_____

Thank you for allowing us to care for your child!
Have a blessed day.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number: NAME: _____ ELIGIBILITY NUMBER: _____

Check here if no eligibility number ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _ _ _ - _ _ - _ _ _ _ ☐ I do not have a Social Security Number