



24007 Franz Road
 Katy, Texas 77493
 (281) 347-5444

ENROLLMENT APPLICATION FOR KIDS 'R' KIDS FRANZ ROAD

GENERAL INFORMATION: CHILD'S INFORMATION

Operation Name: Kids 'R' Kids Franz Road		Director's Name: Meredith Tritico	
Full Name	Nickname	Sex	Date of Birth
Child's Address	Start Date	End Date	Suite Number

MOTHER

FATHER

Name: _____ Street: _____ City: _____ State: _____ Zip: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____ Place of Employment: _____ Work Address: _____ Driver's License #State: _____	Name: _____ Street: _____ City: _____ State: _____ Zip: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____ Place of Employment: _____ Work Address: _____ Driver's License #State: _____
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EMERGENCY CONTACTS

The person's listed below may be contacted in the event of an emergency, AND are also authorized to drop off and pick up this child. List at least 2 names.

Name	Address	Home Phone	Cell Phone	Relationship
1.				
2.				
3.				

AUTHORIZED TO RELEASE

In addition to the parents and emergency contacted above, the following people can pick-up my child. List at least 1 name.

1.				
2.				

Child's Legal Guardians: Both Parents Mother Father Other _____
 Child's Living Arrangements: Both Parents Mother Father Other _____
 Parent's Marital Status: Married Single Separated Divorced Widowed
 Custody Documents on File: Yes No

Child's Doctor: _____ Address: _____ Phone: _____

Name of Hospital or Clinic: _____

Child's Allergies, special medical conditions, or prescribed drugs: _____

Signature: _____ Date: _____



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 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

4. RECEIPT OF WRITTEN OPERATIONAL POLICIES
 I acknowledge receipt of the facility's operational policies, including those for:

<input type="checkbox"/> Discipline and guidance	<input type="checkbox"/> Procedures for the release of children
<input type="checkbox"/> suspension and expulsion	<input type="checkbox"/> Illness and exclusion criteria
<input type="checkbox"/> Emergency plans	<input type="checkbox"/> Procedures for dispensing medicine
<input type="checkbox"/> Procedures for conducting health checks	<input type="checkbox"/> Immunization requirements for children
<input type="checkbox"/> Safe sleep	<input type="checkbox"/> Meals and food practices
<input type="checkbox"/> Procedures for parents to discuss concerns with the director	<input type="checkbox"/> Procedures to visit the center without securing prior approval
<input type="checkbox"/> Procedures for parents to participate in operation activities	<input type="checkbox"/> 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 Lunch Afternoon Snack Early Evening Snack Supper

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	6:00	6:30
Tuesday	6:00	6:30
Wednesday	6:00	6:30
Thursday	6:00	6:30
Friday	6:00	6:30
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: Memorial Hermann Katy Hospital	Address: 23900 Katy Freeway, Katy, TX 77494	Phone Number: 281-644-7000

I give consent for the facility to secure an and all necessary emergency medical care for my child.	Signature – Parent or Legal Guardian
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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 teachers 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 as 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 ride the bus be released to the care of his/her sibling under 18 years old

ADMISSION REQUIREMENT

If you 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 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 ad 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 reasons 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 and hearing screening conflicts with the tenets or practices of a church or religious denomination that I am adherent or member of.

VISION EXAM RESULTS

R 20/	L 20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Signature:		Date Signed:	

HEARING EXAM RESULTS

Ear	1000Hz	2000Hz	4000Hz	Pass or Fail
Right				<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Left				<input type="checkbox"/> Pass <input type="checkbox"/> 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 CONT.

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 months (third dose) 12-15 months (fourth dose)	
Influenza	Yearly, starting 6 months. Two doses are given at least 4 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 – 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:
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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 Signature:	Date Signed:
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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)

<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date:
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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.



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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: