



Enrollment Information

Date of Admission: _____

Child's name: _____ Date of Birth: _____

Child's Address: _____

Hours and days in care : _____

Parent's or Guardian's name: _____

Address (if different): _____

Email Address: _____

Company Name: _____

Phone numbers while child is in care: Mother/Stepmother: _____ Father/Stepfather: _____ Guardian : _____

Parent's Social Security #: _____ # _____ Child's Social Security # _____

Parent's Drivers License # _____ # _____

I Hereby Authorize the day care facility to allow my child to leave with the following persons:

_____ Driver's License # _____ Driver's License # _____

_____ Driver's License # _____ Driver's License # _____

List any special problems that your child may have such as allergies, existing illness, previous serious illness, injuries in the past 12 months, any medication prescribed for long-term continuous use, and any information which the staff should be aware of:

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility or director in charge to take my child to:

Name of Physician : _____ Address: _____ Phone: _____

Name of Hospital: _____ Address: _____ Phone: _____

Signature of Parent or Guardian: _____

TRANSPORTATION (only ages 3 and up)

I hereby give do not give my consent for my child to be transported and supervised by facility's staff:
 on field trips to and from school.

WATER ACTIVITIES

I hereby give do not give my consent for my child to
 splashing pools wading pools swimming pools other bodies of water provided by the facility

Parent's Comments: _____

MEALS

Meals I expect my child to receive:
 breakfast lunch pm snack Initial Here: _____

SCHOOL AGE CHILDREN

My child attends the following school and his/her immunization record is on file and all immunizations and tuberculosis test results are current.

Name of Public School: _____
School Phone Number: _____
School Address: _____

Custody and visiting arrangements (If limited, court documents must be on file.)

HEALTH REQUIREMENTS

Woodbridge Day School 11501 Plano Road Dallas TX, 75035 972-348-5200 214-221-0920 Fax

Name of Child:				Date of Birth:	
IMMUNIZATIONS	Date / dose 1	Date / dose 2	Date / dose 3	Date / dose 4	Date / booster
Hepatitis B					
DTP / DTaP / DT					
Hib					
POLIO IPV or OPV					
MEASLES					
MUMPS					
RUBELLA Varicella (see below)					
Pneumococcal Conjugate Vaccine					
Hepatitis A					
TB TEST (if required)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date: _____		
Signature or stamp of a physician or public health personnel verifying immunization information above. _____					
				Signature	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.					
				Parent's signature	Date
<input type="checkbox"/> I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.					
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:

1. **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.

Health Care Professional's Signature _____
Date

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 will submit it to the child-care operation.

Name and address of health care professional:

Signature - Parent or Legal Guardian _____
Date

VISION	R 20/ _____	L 20/ _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE _____		DATE _____	
HEARING	1000 Hz	2000 Hz	4000 Hz
R			
L			
			<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE _____		DATE _____	

Signature – Parent or Legal Guardian

Date