

Admission Information

Operation Name Kids Campus Learning Center		Director's Name Tammy Jennings / Debbi Parker	
Child's Full Name		Child's Date of Birth	Child's Home Telephone No.
Child's Home Address			
Date of Admission	Date of Withdrawal		
Parent's or Guardians Name		Address (if different from child's address)	
<i>< All EMERGENCY CONTACT and PICK UP information is located on the CHILD & PARENT INFORMATION SHEET ></i>			

Check all that Apply

1. TRANSPORTATION:	I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give <input type="checkbox"/> - consent for my child to be transported and supervised by the operations' employees: <input type="checkbox"/> For emergency care <input type="checkbox"/> on field trips <input type="checkbox"/> to and from home <input type="checkbox"/> to and from school
2. FIELD TRIPS:	I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give <input type="checkbox"/> - my consent for my child to participate in Field Trips at age 3 to 5 years of age.
Parent's Comments:	
3. WATER ACTIVITIES:	I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give <input type="checkbox"/> - 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

I understand that a MORNING SNACK, LUNCH, and AFTERNOON SNACK will be served to my child while at Kids Campus: _____ (please initial)

MY CHILD IS NORMALLY IN CARE AT KIDS CAMPUS ON:

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 at Kids Campus to arrange any and all necessary emergency medical care.

Name of physician	Address of Physician	Phone #
_____	_____	_____

NAME OF EMERGENCY MEDICAL FACILITY

<input type="checkbox"/> Dell Children's Hospital	4900 Mueller Blvd	324-0000
<input type="checkbox"/> Seton Southwest Medical Center	7900 FM 1826 Bldg #1	324-9000
<input type="checkbox"/> other: _____	_____	_____

Signature – Parent or Legal Guardian

List any special information about your child that you may want us to know on the CHILD INFORMATION FORM.

Signature – Parent or Legal Guardian

Date

REQUIRED HEALTH INFORMATION

CHILDREN ATTENDING A SCHOOL IN ADDITION TO KIDS CAMPUS LEARNING CENTER

My Child attends the following school:

<input type="checkbox"/> Patton Elementary	6001 Westcreek Dr. Austin, TX 78749	414-1780
<input type="checkbox"/> Mills Elementary	6201 Davis Lane Austin, TX 78749	841-2400
<input type="checkbox"/> other: _____	_____	_____

CHECK ALL THAT APPLY:

My child's immunization record is on file at the school and all required Immunizations and TB tests are current. Vision and Hearing screening Records are also on file.

My Child has permission to:
 ride a bus to and from his/her elementary school
 be released to his/her sibling(s) under 18 years old

Name and ages of sibling(s) _____

**** STOP HERE AND SIGN BOTTOM ****

< INFORMATION BELOW IS ONLY FOR CHILD(REN) WHO DO NOT ATTEND ANOTHER SCHOOL! >

HEALTH CERTIFICATE

If your child does not attend a pre-kindergarten program or any other program away from Kids Campus, you must obtain a statement signed by your child's HEALTH- CARE PROFESSIONAL indicating he/she is well and able to attend a child care facility. If you plan to get this statement on your child's next visit to his/her doctor, check #3

1. My child's HEALTH-CARE PROFESSIONAL has signed the KIDS CAMPUS HEALTH STATEMENT.
2. My child's HEALTH-CARE PROFESSIONAL has signed a HEALTH STATEMENT that indicates my child is able to attend a child care facility. I have given this statement to Kids Campus Learning Center.
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. I will obtain a signed statement from my child's physician within 12 months of admission and submit it to KIDS CAMPUS.

Name of Healthcare Professional _____

Address _____

VISION AND HEARING SCREENING - Department of Family and Protective Services requires child care centers to have a VISION AND HEARING SCREENING on file for children who will be 4 by September 1st of the current year.

My Child will NOT be 4 years old by September 1st of this year.

My Child will be 4 years old by September 1st of this year. I will provide a VISION AND HEARING SCREENING to Kids Campus by March 1st.

IMMUNIZATION RECORD: Kids Campus must have a current immunization record on file for every child enrolled. Please understand it is your responsibility as a parent to keep your child's immunizations up to date!

I have provided Kids Campus with a copy of my child's most current immunization record.

I am a participant in IMMTRAC so Kids Campus can obtain my child's most recent immunization record Online.

I am NOT a participant in IMMTRAC but I will talk with my child care provider about it.

I do not wish to become a participant of IMMTRAC therefore I will be responsible for providing Kids Campus with my child's most recent shot record.

CHICKEN POX: My child had Chicken Pox on or about (date) _____ and does not need the varicella vaccine.

EXCLUDING YOUR CHILD FROM IMMUNIZATIONS You have the right not to immunize your child(ren) however, please read and understand what Kids Campus must have on file in order to enroll your child if you do not follow the immunization schedule provided by the State!

I am EXCLUDING MY CHILD FROM all or some IMMUNIZATION REQUIREMENTS for reasons of conscience, including a religious belief. I understand that I need to provide Kids Campus with AN OFFICIAL NOTARIZED AFFIDAVIT that is developed and issued by the Department of State Health Services. I also understand that this affidavit is valid for 2 years and I will make sure Kids Campus has a new NOTARIZED form every 2 years.

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

Signature – Parent or Legal Guardian

Date