ADMISSION INFORMATION

Directions: The parent or guardian must fill out this form **entirely** and must return it to the facility no later than the morning of the child's first day of enrollment. We will keep these forms on file in the facility and will be updated by the parent as needed by SMAH to comply with Texas Childcare Licensing Minimum Standards. **Forms must be completed in blue or black ink only**.

CHILD'S INFORMATION:

Child's Full Name: _____ Date of Birth: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____ Sex: Male Female

PARENT'S/ GUARDIAN INFORMATION:

Father's/Guardian Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Cell #: _____ Cell Phone Provider (Verizon, AT&T, ETC) _____

Work # _____ Email: _____

Mother's /Guardian Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Cell #: _____ Cell Phone Provider (Verizon, AT&T, ETC) _____

Work # _____ Email: _____

PRIMARY ACCOUNT HOLDER:

This parent or guardian will be the main account holder for all the payment information. Any ledger cards, tax forms, and receipts will be in the primary account holders name.

Full Name: _____ Signature: _____

Parent's Marital Status: Together Separated Divorced Widowed Other_____

Child lives with: Both Parents Mom Dad Guardian _____

Custody Documents on File: Yes No Please circle the applicable.

PARENT OR GUARDIAN PRIMARY EMERGENCY CONTACT INFORMATION:

This is the parent or guardian with whom we can get in contact with quickly in case of an emergency.

Name: _____ Relationship: _____

Phone Number: _____

EMERGENCY CONTACT INFORMATION: Must be other adult besides the parents or guardians

Full Name: _____ Relationship: _____

Address: _____ City_____ State_____ Zip_____

Cell#: _____ Work#: _____

AUTHORIZED TO PICK UP THE CHILD: One may be the same as the emergency contact

The authorized pick person must be other adults besides parents.

1) Full Name: _____ Phone: _____ Relationship: _____

2) Full Name: _____ Phone: _____ Relationship: _____

3) Full Name: _____ Phone: _____ Relationship: _____

- I authorize Sunshine Montessori Academy Helotes **to release** my child to leave the facility ONLY with the authorized persons listed above. Children will only be released to a parent or guardian or person designated by the parent or guardian after verification of identification.

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:

Child's Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Medical Care Facility: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

I give consent for Sunshine Montessori Academy Helotes to secure any and all necessary emergency medical care for my child and I will be responsible for the applied costs:

_____ _____

Signature of Parent or Legal Guardian **Date**

MEDICAL INFORMATION:

List any special problems that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months and from birth of the child. Any medication prescribed for long-term continuous use and any other information which caregivers and management should be aware of:

Does your child have a doctor diagnosed food allergy? No Yes

A separate form must be submitted for each doctor diagnosed food allergy

Plan submitted on: _____ Director Initials: _____

Child 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) 541-0301 (voice) or (800) 514-0383 (TTY).

_____ _____

Signature of Parent or Legal Guardian **Date**

CONSENT INFORMATION: Please consent to all that apply

1) TRANSPORTATION: I hear by ( ) GIVE ( ) DO NOT GIVE my consent for my child to be transported and supervised by Sunshine Montessori Academy Helotes employees

( ) for emergency care ( ) on field trips

2) FIELD TRIPS (ages 5 thru 12): I hear by ( ) GIVE ( ) DO NOT GIVE my consent for my child to participate in field trips.

3) WATER ACTIVITIES: I hear by ( ) GIVE ( ) DO NOT GIVE my consent for my child to participate in water activities.

( ) sprinkler play during summer time ( ) water table play

MEALS:

Sunshine Montessori Academy Helotes is currently enrolled in the Federal Food Program through the Texas Department of Agriculture and will serve the following meals to your child: **Breakfast, Lunch and Afternoon Snack.**

SCHEDULE:

Part Time students will need to sign up for the same days each week and will only be able to change or substitute upon director approval. Not all requests will be approved

MONDAYS	FROM:	TO:
TUESDAYS	FROM:	TO:
WEDNESDAYS	FROM:	TO:
THURSDAYS	FROM:	TO:
FRIDAYS	FROM:	TO:

SCHOOL AGE CHILDREN:

My child attends the following school

Name of School: _____ Phone Number: _____

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

Address: _____ City: _____ State: _____ Zip: _____

My child has permission to:

( ) Ride a bus

ADMISSION REQUIRMENTS:

If your child does **not** attend pre-kindergarten or school away from Sunshine Montessori Academy Helotes, the following must be provided:

Shot Record: We must receive an updated shot record to be placed in your child's file every time your child gets a vaccination. If your child is not current with licensing standards, we will not be able to care for your child until they are up to date.

Physician Statement: We have provided a physician form for your child's doctor to fill out and sign to be placed in your child's file. Form must be filled out completely and a stamp from the doctor's office included in the designated spot. This form must be submitted within one week of your child's first day of enrollment.

Vision and Hearing Screening: The results of your child's vision and hearing test must be submitted to be placed in their file once your child turns four years old.

_____ _____

Signature of Parent or Legal Guardian **Date**

REQUIREMENTS FOR EXCLUSION:

( ) I have attached a signed and dated affidavit stating that I decline immunization 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.

( ) Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the following statement:

My child had varicella disease (chickenpox) on or about the date of _____ and does not need varicella vaccine.

_____ _____

Signature of Parent or Legal Guardian **Date**

Gang Free Zone:

Under the Texas Penal Code, any area within 1,000 feet of a childcare center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Name of Parent or Guardian Completing Form:

_____ _____

Printed Name **Date**

_____

Signature

For Office Use Only

Date of Enrollment: _____ Director: _____

Date of Disenrollment: _____ Director: _____

Physician Statement

Admission Requirement: If your child does not attend pre-kindergarten or school away from the childcare facility, the following form must be presented when your child is admitted to the childcare facility or within one week of admission. If there are any medical conditions we need to be informed of, please have your physician write it in the space provided.

Childs Name: _____ Birthdate: _____

HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he / she is able to take part in the day care program.

Remarks:

_____

_____

_____

Physicians Office Stamp:

Physicians Signature:

_____

Physicians Printed Name:

_____

Address: _____

City, State, Zip: _____

Phone Number: _____

Date: _____

Sunshine Montessori Academy

"Your Child's success is our success"

Helotes Child Care Center

Infants - Preschool - Afterschool

Food Allergy Emergency Plan

This plan must be signed and dated by your child's health care provider

Child's Name: _____ Date of Birth: _____

Doctor: _____

Address: _____

Phone: _____ Fax: _____

Please complete one form for EACH known Food Allergy

Food child is allergic to: _____

Possible Symptoms if exposed to this food: _____

_____

_____

Specific steps to take if child has an allergic reaction to this food: _____

_____

_____

By signing below, the parent/guardian of this child gives SMAH permission to post the child's food allergy in the food serving and preparation areas.

Doctor Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Physician Office Stamp: