



Early Learning Center

Admission Information

General Information			
Operation's Name: LOBO GYMNASTICS, INC.		Director's Name:	
Child's Full Name:	Child's Date of Birth:	Child Lives With? <input type="radio"/> Both parents <input type="radio"/> Mom <input type="radio"/> Dad <input type="radio"/> Guardian	
Child's Home Address:	Date of Admission:	Date of Withdrawal:	
Name of Parent or Guardian 1:	Address of Parent or Guardian 1 <i>if different from the child's</i> :		
Name of Parent or Guardian 2:	Address of Parent or Guardian 2 <i>if different from the child's</i> :		
List phone numbers and email addresses below where parents or guardian may be reached while child is in care.			
Parent 1 Area Code and Phone No:	Parent 2 Area Code and Phone No:	Guardian Area Code and Phone No:	Custody Documents on File? <input type="radio"/> Yes <input type="radio"/> No
Parent 1 Email Address:	Parent 2 Email Address:	Guardian Email Address:	
In case of an emergency, call:			
Name of Emergency Contact:	Relationship:	Area Code and Phone No.:	
Address:	City:	State:	Zip Code:
I authorize the childcare operation to release my child to leave the childcare operation ONLY with the following persons. Please list the name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.			
Name:		Area Code and Phone No.:	
Name:		Area Code and Phone No.:	
Name:		Area Code and Phone No.:	
Name:		Area Code and Phone No.:	
Consent Information			
1. Transportation:			
I give consent for my child to be transported and supervised by the operation's employees (Check all that apply). <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:			
<input type="radio"/> I give consent for my child to participate in field trips. <input type="radio"/> 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 (Check all that apply).

☐ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds

Is your child able to swim without assistance: ☐ Yes ☐ No

If not, your child is required to wear a life jacket while in or near a swimming pool.

Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming? ☐ Yes ☐ No

If yes, your child is required to wear a US Coast Guard approved life jacket while in or near a swimming pool.

Do you want your child to wear a life jacket while in or near a swimming pool? ☐ Yes ☐ No

*A competent swimmer can enter and exit a pool safely on their own, tread water or float on their back for one minute, and swim 25 yards with no assistance.

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

- | | |
|--|--|
| <input type="checkbox"/> Discipline and guidance
<input type="checkbox"/> Suspension and expulsion
<input type="checkbox"/> Emergency plan
<input type="checkbox"/> Procedures for conducting health checks
<input type="checkbox"/> Safe sleep
<input type="checkbox"/> Procedures for parents to discuss concerns with the director
<input type="checkbox"/> Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
<input type="checkbox"/> Procedures for parents to participate in operation activities | <input type="checkbox"/> Procedures for the release of children
<input type="checkbox"/> Illness and exclusion criteria
<input type="checkbox"/> Procedures for dispensing medications
<input type="checkbox"/> Immunization requirements for children
<input type="checkbox"/> Meals and food service practices
<input type="checkbox"/> Procedures to visit the center without securing prior approval
<input type="checkbox"/> Procedures for supporting inclusive services
<input type="checkbox"/> Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline, and CCR website |
|--|--|

5. Meals:

I understand that the following meals will be served to my child while in care (Check all that apply):

☐ 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	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

7. Receipt of Parent's Rights:

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

Child's Parent or Legal Guardian

Date Signed

8. Child's Special Care Needs (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Environmental allergies | <input type="checkbox"/> Limitations or restrictions on child's activities |
| <input type="checkbox"/> Food intolerances | <input type="checkbox"/> Reasonable accommodations or modifications |
| <input type="checkbox"/> Existing illness | <input type="checkbox"/> Adaptive equipment (<i>include instructions below</i>) |
| <input type="checkbox"/> Previous serious illness | <input type="checkbox"/> Symptoms or indications of complications |
| <input type="checkbox"/> Injuries and hospitalizations (<i>past 12 months</i>) | <input type="checkbox"/> Medications prescribed for continuous long-term use |
| <input type="checkbox"/> Other: _____ | |

Explain any needs selected above:

Does your child have diagnosed food allergies? ☐ Yes ☐ No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit <https://www.ada.gov/resources/child-care-centers/>. 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**9. School Age Children**

My child attends the following school:

School Area Code and Phone No.:

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 or her sibling under 18 years old

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

- ☐
- Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization For Emergency Medical Attention

In the event I cannot be reached to arrange for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician	Address	Area Code and Phone No.
Name of Emergency Care Facility	Address	Area Code and Phone No.

I give consent for the facility to secure all necessary emergency medical care for my child.

Signature-Parent or Legal Guardian_____
Date Signed

Requirements for Exclusion from Compliance

- ☐ 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

Right Eye 20/

Left Eye 20/

☐ Pass☐ Fail

Signature

Date Signed

Hearing Exam Results

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

Signature

Date Signed

Admission Requirement

If your child does not attend pre-kindergarten or school away from the childcare operation, one of the following must be presented when your child is admitted to the childcare operation or within one week of admission. *(Select **only one** option.)*

- ☐ 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.
- ☐ A signed and dated copy of a health care professional's statement is attached.
- ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or I am a member of. I have attached a signed and dated affidavit stating this.
- ☐ 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 childcare operation.

Name of Health Care Professional, if selected

Address of Health Care Professional, if selected

Signature — Health Care Professional

Date Signed

Signature — Parent or Legal Guardian

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)	
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.	

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 _____ and does not need varicella vaccine.

Signature-Parent or Legal Guardian

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 childcare center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: <https://hhs.texas.gov/policies-practices-privacy#security>.

Signatures

Child's Parent or Legal Guardian

Date Signed

Center Designee

Date Signed

Physician or Public Health Personnel Verification

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

Signature

Date Signed