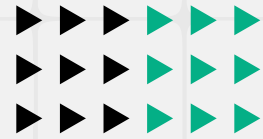




CHILDCARE &  
LEARNING  
CENTER



# ***ENROLLMENT DOCUMENTS***

**AGES 6 WEEKS - 12 YEARS**  
**1407 S. HWY 69, NEDERLAND TX, 77627**  
**(409) 724-7114**

**OPEN YEAR ROUND**  
**MONDAY - FRIDAY**  
**6:30 a.m. - 6:00 p.m.**

# ADMISSION INFORMATION

## **CHILD'S INFORMATION:**

Child's name: \_\_\_\_\_

Child's DOB: \_\_\_\_\_

The child lives with: Both Parents, Mom, Dad, or Guardian (Please circle the applicable)

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

## **PARENT/GUARDIAN INFORMATION:**

Parent/Guardian name: \_\_\_\_\_ Parent/Guardian name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

## **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 holder's name.

Full Name: \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

# AUTHORIZED PICK UP LIST

## THE FOLLOWING PEOPLE ARE ALLOWED TO PICK UP:

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
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Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**Dear Parent/Guardian,**

**At KT, we take photos of students during their activities on the premises. We would like your consent to publish or use any photos in which your child may appear.**

**Please indicate which of the following options you are comfortable with:**

- **In-class projects**\_\_\_
- **Bulletin Boards**\_\_\_
- **Private Facebook page**\_\_\_
- **Public Facebook page**\_\_\_
- **Our Website**\_\_\_
- **None**\_\_\_

**If you wish to withdraw your authorization at any time, please notify us in writing. We guarantee that names will not be included to protect the privacy of the child.**

**Thank you for your cooperation.**

**Parent/Guardian signature**\_\_\_\_\_ **Date**\_\_\_\_\_

# INFANT CARE INSTRUCTIONS

**CHILD'S NAME:**

**CHILD'S DOB:**

**ALLERGIES:**

**FEEDING INFORMATION:**

**WHAT:**

**WHEN:**

**HOW MUCH:**

**SPECIAL INSTRUCTIONS:**

**WHAT:**

**WHEN:**

**HOW MUCH:**

**SPECIAL INSTRUCTIONS:**

**WHAT:**

**WHEN:**

**HOW MUCH:**

**SPECIAL INSTRUCTIONS:**

**OTHER HELPFUL INFO:**

**PACIFIER:**

**YES\_\_**

**NO\_\_**

**ANY OTHER INFO NEEDED:**

**SLEEPING SCHEDULE:**

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**\*Parents must fill out an updated Infant Care Instructions form every 30 days**

## Admission Information

Use this form to collect all required information about a child enrolling in day care.

**Directions:** The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

### General Information

Operation's Name:		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 Completing Form:		Address of Parent or Guardian <i>(if different from the child's)</i> :	
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? <input type="radio"/> Yes <input type="radio"/> No
<b>In case of an emergency, call:</b>			
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:
Address:			
I authorize the child care operation <b>to release</b> my child to leave the child care operation <b>ONLY</b> with the following persons. Please list 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.:	

### Consent Information

#### 1. Transportation:

I give consent for my child to be transported and supervised by the operation's employees (Check all that apply).

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 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 no, what type of assistance is needed:

**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"/> Procedures for 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 medications  |
| <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 service 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"/> Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions | <input type="checkbox"/> Procedures for supporting inclusive services   |
| <input type="checkbox"/> Procedures for parents to participate in operation activities                                       | <input type="checkbox"/> Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL 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	<input type="text"/>	<input type="text"/>
Tuesday	<input type="text"/>	<input type="text"/>
Wednesday	<input type="text"/>	<input type="text"/>
Thursday	<input type="text"/>	<input type="text"/>
Friday	<input type="text"/>	<input type="text"/>
Saturday	<input type="text"/>	<input type="text"/>
Sunday	<input type="text"/>	<input type="text"/>

**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

**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	Phone No.
_____	_____	_____
Name of Emergency Care Facility	Address	Phone No.
_____	_____	_____

I give consent for the facility to secure any and 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="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Pass <input type="radio"/> Fail
Left	<input type="text"/>	<input type="text"/>	<input type="text"/>	<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 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. *(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 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 child care 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 [date] and does not need varicella vaccine.

Signature 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](http://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 child care 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 a physician or public health personnel verifying immunization information above:

Signature Date Signed

# Automated Payment Processing



Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

## ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) \_\_\_\_\_ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

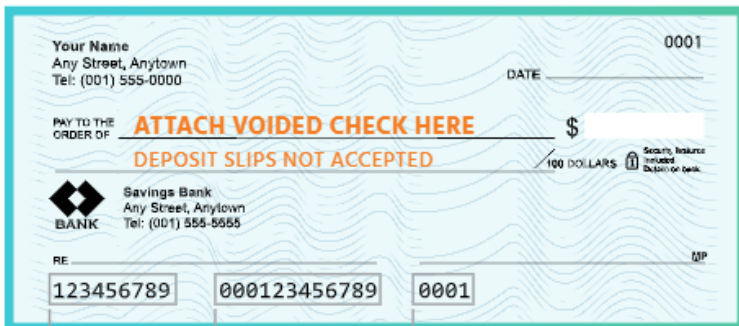
### COMPLETE ONE SECTION ONLY

#### SECTION A (Credit Card)

Cardholder Name	Phone #		
Cardholder Address	City	State	Zip
Account Number	Expiration Date		
Cardholder Signature	Date		

#### SECTION B (Bank Account)

Your Name	Phone #			
Address	City	State	Zip	
Bank or Credit Union Name	Bank or Credit Union Address	City	State	Zip
Routing Transit Number (see sample below)	Account Number (see sample below)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	
Authorized Signature	Date			



ROUTING NUMBER

ACCOUNT NUMBER

CHECK NUMBER

#### FOR OFFICIAL USE ONLY

_____
Date Received
_____
Employee Signature

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