

FELLOWSHIP CHRISTIAN ACADEMY

16425A Old Richmond Rd., Sugar Land, TX 77498
(281) 495-1814 (281) 495-1831 Fax

ADMISSION INFORMATION

Present date _____ Starting Date _____ Grade _____

Child's Full Name _____
First Middle Last Answers to

Date of Birth ___/___/___ Male ___ Female ___

PARENT/GUARDIAN # 1

Mr/Mrs/Ms _____ Home Phone _____

Home Address _____ Lives with student? Yes No

City/State/Zip _____ Billing Party Yes No

Relation to Student _____ Cell Phone _____

Employer/Occupation _____ Work Phone _____

PARENT/GUARDIAN # 2

Mr/Mrs/Ms _____ Home Phone _____

Home Address _____ Lives with student? Yes No

City/State/Zip _____ Billing Party Yes No

Relation to Student _____ Cell Phone _____

Employer/Occupation _____ Work Phone _____

Signature of Parent/Guardian

Date
School Year: 2009 - 2010

Child's Name: _____

*Other than parents, **CHILD WILL BE RELEASED ONLY TO PERSONS INDICATED BELOW** (Must include at least TWO local persons to call for illness, accident, late pick-up, or other emergency reasons). Please list them in the order of preference for us to contact.*

Mr/Mrs/Ms _____ Home Phone _____

Home Address _____ Lives with student? Yes No

City/State/Zip _____ Billing Party Yes No

Relation to Student _____ Cell Phone _____

Employer/Occupation _____ Work Phone _____

Mr/Mrs/Ms _____ Home Phone _____

Home Address _____ Lives with student? Yes No

City/State/Zip _____ Billing Party Yes No

Relation to Student _____ Cell Phone _____

Employer/Occupation _____ Work Phone _____

Mr/Mrs/Ms _____ Home Phone _____

Home Address _____ Lives with student? Yes No

City/State/Zip _____ Billing Party Yes No

Relation to Student _____ Cell Phone _____

Employer/Occupation _____ Work Phone _____

Family Information

Names and ages of other children in the family _____

Has your child ever been in school before? _____ If yes, where _____

Church membership or religious preference _____

Photograph Release

I release Fellowship Christian Academy to photograph and/or videotape my child while participating in daily activities, and to use the photographs and or videos in photograph displays or other publications showing these daily activities.

Signature of Parent/Guardian

Date

School Year: 2009 - 2010

EMERGENCY INFORMATION

Child's Name _____ Birthdate _____ Weight _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Father's Name _____ Daytime Phone _____
Cell Phone _____

Mother's Name _____ Daytime Phone _____
Cell Phone _____

Emergency Contact _____ Daytime Phone _____
Cell Phone _____

Consent to medical care and treatment of minor child

I, _____, hereby give permission that my child _____, may be given emergency treatment, to include first aid and CPR by a qualified staff member of Fellowship Christian Academy. I further authorize and consent to medical, surgical and hospital care, treatment, and procedures to be performed for my child by my child's regular physician, or when that physician cannot be reached, by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health if I cannot be contacted. In such a case, I waive my right to informed consent to such treatment.

I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I further authorize said center to take my child to a hospital, and I agree that I will pay all physicians and hospital bills, and said center shall not be responsible for them.

Signature of Parent/Guardian

Date

School Year: 2009 – 2010

Child's Name _____

Medical Information

Known allergies to medications and other substances

Are there any restrictions on normal physical activities indicated?

___ Yes ___ No

If yes, please specify: _____

Does the child have any chronic medical conditions necessitating dietary supplements or restrictions, medication, or avoidance of allergens?

___ Yes ___ No

If yes, please specify: _____

Does the child have any known allergies?

___ Yes ___ No

If yes, special attention required: _____

Does the child have asthmatic problems?

___ Yes ___ No

If yes, special attention required: _____

Hospital Preference _____

Insurance Carrier _____

Group Number _____ Policy/Individual Number _____

Child's Doctor _____ Phone _____

Address _____

Child's Dentist _____ Phone _____

Address _____

Signature of Parent/Guardian

Date
School Year: 2009 – 2010

ADMISSION INFORMATION

Operation Name		Director's Name	
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 Guardian's Name		Address (if different from child's address)	
List telephone numbers below where parents/guardian may be reached while child will be in care:			
Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.	Cell Phone No
Give the name, address and phone number of person to call in case of an emergency if parents / guardian cannot be reached:			Relationship
I hereby authorize the childcare operation to allow my child to leave the childcare operation ONLY with the following persons. Please list name & telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.			

CHECK ALL THAT APPLY: I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give – consent for my child to be transported and supervised by the operation's employees:			
1. <input type="checkbox"/> TRANSPORTATION:			
<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. <input type="checkbox"/> FIELD TRIPS: I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give – my consent for my child to participate in Field Trips:			
Parent's Comments:			
3. <input type="checkbox"/> WATER ACTIVITIES: I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give – 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			
4. <input type="checkbox"/> RECEIPT OF WRITTEN OPERATIONAL POLICIES:			
I acknowledge receipt of the facility's operational policies including those for discipline and guidance.			
5. I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:			
<input type="checkbox"/> None <input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack			
6. MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:			
<input type="checkbox"/> Mondays	from:	to:	
<input type="checkbox"/> Tuesdays	from:	to:	
<input type="checkbox"/> Wednesdays	from:	to:	
<input type="checkbox"/> Thursdays	from:	to:	
<input type="checkbox"/> Fridays	from:	to:	
<input type="checkbox"/> Saturdays	from:	to:	
<input type="checkbox"/> Sundays	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 to take my child to:		
Name of Physician:	Address:	Ph.#:
Name of Emergency Medical Care Facility:	Address:	Ph.#:
I give consent for the facility to secure any and all necessary emergency medical care for my child.		
_____ Signature - Parent or Legal Guardian		

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

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

SCHOOL AGE CHILDREN:

My child attends the following school:

Name of School and Address School Ph.#

CHECK ALL THAT APPLY:

His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

My child has permission to: walk to and from school,
 ride a bus, and/or be released to the care of his/her sibling(s) under 18 years old.

Name of sibling(s): _____

IMMUNIZATION RECORD:

I have provided the childcare operation with a copy of my child's most current immunization record.

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 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

ADMISSION INFORMATION

HEALTH REQUIREMENTS

Name of Child:

Date of Birth:

Age ► Vaccine ▼	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	2-3 Yrs	4-6 Yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus influenzae type b											
Pneumococcal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											

TB TEST (if required)

Positive

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

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

www.dshs.state.tx.us/immunize/public.shtm

Signature – Parent or Legal Guardian

Date