Austin Peace Academy
ENROLLMENT INFORMATION

Facility Name Austin Peace Academy		Director's Name DIANA ABDI	
Child's Name		Date of Birth	Child's Home Telephone No.
Child's Address			
Date of Admission	Date of Withdrawal	Hours and days child will be in care	
Parent's or Guardian's Name		Address (if different from child's address)	
List telephone numbers where parents/guardian may be reached while child will be in care:	**Mother's Telephone No.**	**Father's Telephone No.**	**Guardian's Telephone No.**
Give name of person to call in case of an emergency if parents / guardian cannot be reached:		**Telephone No.**	**Relationship**
I hereby authorize the day care facility to allow my child to leave the day care facility ONLY with the following persons. (NAME and PHONE NUMBER)			

CHECK ALL THAT APPLY:

1. ☐ **TRANSPORTATION:** I hereby ☐ give ☐ do not give – my consent for my child to be transported and supervised by facility's staff:

☐ on field trips ☐ to and from home ☐ to and from school

2. ☐ **WATER ACTIVITIES:** I hereby ☐ give ☐ do not give – my consent for my child to participate in water activities:

☐ splashing pools ☐ wading pools ☐ swimming pools ☐ other bodies of water provided by the facility

3. ☐ **FIELD TRIPS:** I hereby ☐ give ☐ do not give – my consent for my child to participate in Field Trips:

Parent's Comments :

4. ☐ **SCHOOL AGE CHILDREN**: My child attends the following school and his / her immunization record is on file at the school and all immunizations and tuberculosis test are current.

Name of School and Address _____ School Ph.# _____

5. ☐ **RECEIPT OF PARENT'S GUIDE**
I acknowledge receipt of "A Parent's Guide to Day Care".

_____
Signature - Parent or Legal Guardian

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

_____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:		
Name of Physician :	Address :	Ph.# :
Name of Hospital :	Address :	Ph.# :
I give consent for this facility to secure any and all necessary emergency medical care for my child.		

_____
Signature - Parent or Legal Guardian

Austin Peace Academy
HEALTH REQUIREMENTS

Name of Child:	**Date of Birth** :

IMMUNIZATIONS	**Date / dose 1**	**Date / dose 2**	**Date / dose 3**	**Date / booster**	**Date / booster**
DTP / DTaP / DT					
POLIO **IPV or OPV**					
MEASLES Rubeola/Serampion					
MUMPS					
RUBELLA					
Hib					
Hepatitis A					
Hepatitis B					
TB TEST (if required)	☐ Positive	☐ Negative	Date :		
Varicella (see below)					

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

_____ _____ _____ _____
Signature - Physician or Health Personnel Date Signature - Staff Making Handwritten Copy of Record Date

ADMISSION REQUIREMENT: One of the following must be presented when your child (under the age of 5 years) is admitted to the day care facility or within one week of admission. Check to indicate the option you select:

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

_____ _____
Physician's Signature Date

☐ A copy of the medical screening form of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, if no referral for further diagnosis and treatment is indicated.

☐ A form or written statement from a health service or clinic.

If you do not have any of the above:

☐ PARENT'S STATEMENT: My child has been examined within the past year by a licensed physician and is able to participate in the day care program:

Name and address of Physician **OR** address of EPSDT Screening Site:

☐ Within the next 12 months, I will obtain a physician's statement, a copy of the medical screening form from the EPSDT Program, or a form or statement from a health service or clinic and will submit it to the day care facility.

OR

☐ My child has an appointment for a physical examination:

Date: Name and Address of Physician **OR** Address of EPSDT Screening Site:

I will submit the physician's statement, EPSDT form, or health service or clinic form to the day care facility following the examination.

_____ _____
Signature - Parent or Legal Guardian Date

HEARING	**DATE**		**SIGNATURE**	
Hz	**1000**	**2000**	**4000**	PASS ☐
R				
L				FAIL ☐
VISION	**DATE**		**SIGNATURE**	
R20/ _____	**L20/** _____			PASS ☐ FAIL ☐

NOTE: If medical diagnosis and treatment and / or immunization and TB testing conflict with your religious beliefs, you must sign an affidavit to that effect and attach it to this form. If immunization and / or TB testing would be injurious to your child or family, you must obtain a certificate (signed by a physician) to that effect and attach it to this form.