Admission Packet 2024-2025

This form must be filled out in its entirety.

GENERAL INFORMATION

Operation's Name: ______CORNERSTONE KIDS PRESCHOOL________________ Director's Name: ______LELA KING_____

Child's Full Name: ____ Child's Date of Birth: ____/____/_______

Child lives with: O Both parents O Mom O Dad O Guardian Custody documents on file? O Yes O No

Date of Admission: ____/____/_______ Date of Withdraw: ____/____/_______

Child's full home address: ____

Name of Mom: ____________________ Name of Dad: ____________________ Name of guardian: ____________________

Mom's phone number: _____-_____-__________ Mom's email address: ____

Dad's phone number: _____-_____-__________ Dad's email address: ____

Guardian's phone number: _____-_____-_________ Guardian's email address: _____________________________________

EMERGENCY CONTACT (A contact that is different from parents/guardian)

Name of emergency contact: ______________________________________ Relationship: ________________________

Full address: ____ Phone number: ______________________

AUTHORIZATION FOR PICK UP

1. Name: ____ Relationship: ______________________

   Full address: ____ Phone number: ____________________

2. Name: ____ Relationship: ______________________

   Full address: ____ Phone number: ____________________

3. Name: ____ Relationship: ______________________

   Full address: ____ Phone number: ____________________

CONSENT INFORMATION

1. **Transportation**: I give consent for my child to be transported and supervised by the operation's employees?

O For emergency care

2. **Water Activities**: I give consent for my child to participate in the following water activities (check all that apply).

O Water table play O Sprinkler play O Splashing or wading pools

3. **Receipt of Written Operational Policies:** I acknowledge receipt of the facility's operational policies, including those for (check all that apply);

O Suspension and expulsion

O Emergency plans

O Procedures for conducting health checks

O Meals and food service practices

O Procedures for parents to discuss concerts with the Directors

O Procedures to visit the center without securing prior approval

O Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website

O Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions

O Illness and exclusion criteria

O Procedures for dispensing medications

O Immunization requirements for children

O Safe sleep

O Procedures for supporting inclusive services

O Procedures for parents to participate in operation activities

O Discipline and guidance

O Procedures for release of children

4. **Meals**: I understand that I, the parent/guardian will provide the following meals and Cornerstone Kids Preschool will serve them to my child while in their care (check all that apply);

O Lunch O Afternoon snack

DAYS IN CARE

My child is normally in care at Cornerstone Kids Preschool on the following days during the times of 8:30 am- 3:30 pm;

O Monday O Tuesday O Wednesday O Thursday

CHILD'S SPECIAL CARE NEEDS (check all that apply)

O Environmental allergies

O Food intolerances

O Existing illnesses

O Previous serious illness

O Injuries and hospitalizations (past 12 months)

O Other: ___________________________________

O Limitations or restrictions on child's activities

O Reasonable accommodations or modifications

O Adaptive equipment (including instructions attached)

O Symptom or indications of complications

O Medications prescribed for continuous long-term use

Does your child have diagnosed food allergies? O Yes O No Food Allergy Emergency Plan submit 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*

EVALUATIONS Has your child been evaluated for services at a local private doctor's office, through ECI (Early Childhood Intervention), or at a local Independent School District?

O Yes (If yes, check all that apply) O No

O Speech Therapy O Occupational Therapy O Physical Therapy

O Hearing/Vision Services O Qualified for local ISD school-based program O Nutrition Services

O Behavioral Therapy

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:

Physician Information

Name of Physician: ____ Phone number: _____-_____-_________

Physician's address: ____

Hospital Information

Name of Hospital: ____ Phone number: _____-_____-_________

Hospital's address: ____

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*

SHOT RECORDS/AFFIDAVIT Parents must provide a signed or stamped shot record from their child's pediatrician's office within the first 30 days of enrollment. If your child does not receive vaccines, please complete the *Affidavit Only: Requirements for Exclusion from Compliance* below. Affidavits are due within the first 90 days of enrollment.

VISION EXAM RESULTS (All 4-year-olds as of September 1st)

Right Eye 20/______ Left Eye 20/______ O Pass O Fail

____ _____/_____/__________

Physician's Signature *Date signed*

HEARING EXAM RESULTS (All 4-year-olds as of September 1st)

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				O Pass O Fail
Left				O Pass O Fail

____ _____/_____/__________

Physician's Signature *Date signed*

SCHOOL AGE CHILDREN (kindergarten through completed 5th grade only)

My child's school: ____ School phone number: _____-_____-_________

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

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 – Parent or legal guardian *Date signed*

ADDITIONAL INFORMATION REGUARDING IMMUNIZATIONS

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm

PRIVACY STATEMENT

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

PARENT/GUARDIAN SIGNATURES

____ _____/_____/__________

Signature – Parent or legal guardian *Date signed*

____ _____/_____/__________

Director's Signature *Date signed*