

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: ☐ Both parents ☐ Mom ☐ Dad ☐ Guardian	
Child's Home Address:	Date of Admission:	Date of Withdrawal:	
Name of Parent or Guardian 1:	Address of Parent or Guardian 1 if different from the child's:		
Name of Parent or Guardian 2:	Address of Parent or Guardian 2 if different from the child's:		
List phone numbers below where parents or guardian may be reached while child is in care. This cannot be the name of a parent			
Parent 1 Area Code and Phone No.:	Parent 2 Area Code and Phone No.:	Guardian's Area Code and Phone No.:	Custody Documents on File: ☐ Yes ☐ No
In case of an emergency, when the parent or guardian cannot be reached, call:			
Name of Emergency Contact:	Relationship:	Area Code and Phone No.:	
Address:			
I authorize the child care operation to release my child to leave the child care operation only 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, 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 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 the following. Check all that apply.

- | | |
|--|--|
| ☐ Discipline and guidance | ☐ Procedures for release of children |
| ☐ Suspension and expulsion | ☐ Illness and exclusion criteria |
| ☐ Emergency plans | ☐ Procedures for dispensing medications |
| ☐ Procedures for conducting health checks | ☐ Immunization requirements for children |
| ☐ Safe sleep | ☐ Meals and food service practices |
| ☐ Procedures for parents to discuss concerns with the director | ☐ Procedures to visit the center without securing prior approval |
| ☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions | ☐ Procedures for supporting inclusive services |
| ☐ Procedures for parents to participate in operation activities | ☐ 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.

Signature — Parent or Legal Guardian

Date Signed

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

- | | |
|--|--|
| ☐ Environmental allergies | ☐ Limitations or restrictions on child's activities |
| ☐ Food intolerances | ☐ Reasonable accommodations or modifications |
| ☐ Existing illness | ☐ Adaptive equipment, include instructions below |
| ☐ Previous serious illness | ☐ Symptoms or indications of complications |
| ☐ Injuries and hospitalizations in the past 12 months | ☐ Medications prescribed for continuous long-term use |
| ☐ 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 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 their sibling younger than 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 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				☐ Pass ☐ Fail
Left				☐ Pass ☐ 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 they are 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 _____

When first enrolled a parent statement of care will suffice but
After 12 months of enrollment we must receive a Health Care Professional's statement for children that are not enrolled in the public school system.

Vaccine Information

The following vaccines require multiple doses over time. 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 six to 18 months after the first dose.	

Varicella for Chickenpox

Varicella, the vaccine for chickenpox, is not required if your child has had chickenpox disease. If your child has had chickenpox, complete the statement: My child had varicella disease, chickenpox, on or about [date] and does not need varicella vaccine.

Signature _____

Date Signed _____

Additional Information About Immunizations

For additional information about 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 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 _____

This must be filled out entirely. Even if you do not qualify we are required to have one for each child enrolled.

**INSTRUCTIONS FOR
CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM
(CHILD CARE)**

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children and household members.

Part 2: List the eligibility number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits. The SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form. A Social Security Number is **not** necessary.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

If some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.

Part 2: If the household does not have an eligibility number, skip this part.

Part 3: Applies only to parents/guardians of children in Tier II Day Care Homes. Sponsors must provide the *List of Eligible Federal/State Funded Programs* (H1660), with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and **other deductions**. **You should be able to find it on your stub or your boss can tell you.**

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, TANF, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members
(First, Middle Initial, Last)

CHECK IF A FOSTER CHILD (THE
LEGAL RESPONSIBILITY OF A
WELFARE AGENCY OR COURT)
* IF ALL CHILDREN LISTED BELOW
ARE FOSTER CHILDREN, SKIP TO
PART 5 TO SIGN THIS FORM.

CHECK
IF NO INCOME

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. If no one receives these benefits, skip to part 3.

NAME: _____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number: NAME: _____ ELIGIBILITY NUMBER: _____

Check here if no eligibility number ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List only household members with income) (Example) Jane Smith	B. Gross income and how often it was received Note: Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	\$200/weekly	\$150/twice a month	\$100/monthly	\$200/bi-monthly
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: * * * - * * - _____ ☐ I do not have a Social Security Number



This page is for childcare staff to complete.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:

- ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:

- ☐ Asian
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

- ☐ I do elect to allow my household information to be disclosed.
☐ I do not elect to allow my household information to be disclosed.

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____

Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free _____ Reduced _____ Denied _____ Tier I _____ Tier II _____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

Privacy Act Statement:

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement:

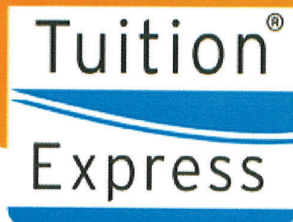
In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
(2) fax: (833) 256-1665 or (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.



This must be filled out and returned. Payments or pay arrangements not received by Tuesday at 6:30 will be processed Wednesday morning.
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)	☐ Checking	☐ Savings	
Authorized Signature	Date			

For Official Use Only

Date Received

Employee Signature

John Sample Mary Sample 123 Nice Street Anytown, USA	BANK OF THE WEST 555-555-5555	00226
Pay to the order of: Attach Voided Check Here \$		
Deposit slips not accepted Dollars		
123456789	1000330	0226
Routing Number	Account Number	Check Number

A service of



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PAID HOLIDAY CLOSINGS

2026

New Year's Day- January 1st

President's Day (Teacher In-service)-February 16th

Good Friday- April 3rd

Memorial Day- May 25th

Independence Day- July 3rd

Labor Day- September 7th

Columbus Day (Teacher In-Service)- October 12th

Thanksgiving- November 26th and 27th

Christmas- December 24th and 25th

New Year's Eve- December 31st

What to bring the first day:



Toddlers & 2's Classroom

ALL ITEMS SHOULD BE LABELED WITH YOUR CHILD'S NAME

Pull-Ups and 1 package of wipes

Water Bottle (refillable)

Blanket

Small Pillow



Or a bedroll / nap mat

Lovie or Comfort Item

2 changes of clothes **including 1 pair of shoes** (seasonally appropriate)

Family Picture (can email: Terrystreehousedenton@gmail.com or bring a printed one)



2/3's and 3's Classroom

ALL ITEMS SHOULD BE LABELED WITH YOUR CHILD'S NAME

Pull-Ups and 1 package of wipes (if needed)

Water Bottle (refillable)

Blanket

Small Pillow



Or a bedroll / nap mat

Lovie or Comfort Item

5 changes of clothes **including 1 pair of shoes** (seasonally appropriate)

Family Picture (can email: Terrystreehousedenton@gmail.com or bring a printed one)



4's and Pre-K Classroom

ALL ITEMS SHOULD BE LABELED WITH YOUR CHILD'S NAME

Water Bottle (refillable)

Blanket

Small Pillow



Or a bedroll / nap mat

Lovie or Comfort Item

2 changes of clothes **including 1 pair of shoes** (seasonally appropriate)

Family Picture (can email: Terrystreehousedenton@gmail.com or bring a printed one)
