



# Faith Academy Admission Form

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month day year

Child's Name: \_\_\_\_\_  
First Middle Last

Child's Address: \_\_\_\_\_  
Street Town State Zip

Parent or Guardian 1	Parent or Guardian 2
Name:	Name:
Address:	Address:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Email:	Email:

### Days of Attendance:

- Mondays  from: \_\_\_\_\_ to: \_\_\_\_\_
- Tuesdays  from: \_\_\_\_\_ to: \_\_\_\_\_
- Wednesdays  from: \_\_\_\_\_ to: \_\_\_\_\_
- Thursdays  from: \_\_\_\_\_ to: \_\_\_\_\_
- Fridays  from: \_\_\_\_\_ to: \_\_\_\_\_

**My child may leave Faith Academy ONLY with the following persons.**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Today's Date



# Faith Academy Admission Form

## In Case of Emergency

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

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

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

Relationship: \_\_\_\_\_

## 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: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Emergency Medical Care Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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:

Allergies: \_\_\_\_\_

Medication: \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Today's Date



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## CHECK ALL THAT APPLY:

### 1. TRANSPORTATION:

I hereby \_\_\_give\_\_\_do not give – consent for my child to be transported and supervised by the operation's employees:

\_\_\_ For emergency care

\_\_\_ On field trips

\_\_\_ From school (to be offered in September at start of new year)

### 2. FIELD TRIPS:

I hereby \_\_\_give\_\_\_do not give – my consent for my child to participate in Field Trips.

**Parent's Comments:**

### 3. WATER ACTIVITIES:

I hereby \_\_\_give\_\_\_do not give– my consent for my child to participate in Water Activities:

\_\_\_ Sprinkler play

\_\_\_ Water table play

\_\_\_ Splashing/wading pools

\_\_\_ Swimming pools

### 4. 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:

\_\_\_ Breakfast (at extra charge and ends at 8:00am)

\_\_\_ AM Snack

Child will bring\_Lunch

\_\_\_ PM Snack

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Today's Date



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## ADMISSION REQUIREMENTS:

### Immunization Record

\_\_\_\_ I have provided Faith Academy with a copy of my child's most current immunization record.

**One of the following must be presented when your child is admitted to Faith Academy 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 \_\_\_\_\_

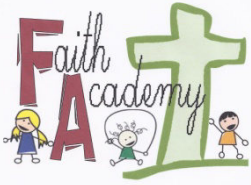
2. \_\_\_\_ A signed and dated copy of a health care professional's statement is attached.

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.

<b>VISION</b>	R 20/ _____	L 20/ _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE _____		DATE _____	
<b>HEARING</b>	<b>1000 Hz</b>	<b>2000 Hz</b>	<b>4000 Hz</b>
R			
L			
			<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE _____		DATE _____	

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Today's Date



# Faith Academy Admission Form

## HEALTH REQUIREMENTS

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

	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											
Pneumococccal											
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](http://www.dshs.state.tx.us/immunize/public.shtm)

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Today's Date