Little Dove Learning Center

2655 Talley Rd.
San Antonio,Tx 78253
(210) 679-5100
Email: littledovelc@gmail.com WEB Site: littledovelc.org
Director: Ofie Ruiz

Date of admission

Date of withdrawal

☐ full time
☐ part time 3 days
☐ part time 2 days
☐ Mothers Day Out
☐ After School

Child Information

Date of Birth ☐Male ☐Female

First Name M.I. Last Name

Address

Home Number w/ZIP Code PIN # (4 Digits , Numbers Only)

List any special conditions 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 the caregiver should be aware of:

Pediatrician's Name Office Number w/ZIP Code

Photographs: May we take and maintain photos of your child for center purposes? ☐ Yes ☐ No

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: Phone:

Hospital: Address: Phone:

I give consent for the facility to secure any and all necessary emergency medical care for my child. Signature-Parent or Legal guardian

Parent/Guardian Information

Mother/Guardian First Name Last Name

Address/City/Zip

Home Number Cell Number Work Number

Employed By Email Address

Father/Guardian First Name Last Name

Address/City/Zip

Home Number Cell Number Work Number

Employed By Email Address

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 employee

☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. FIELD TRIPS I hereby ☐ give ☐ do not give -consent for my child to participate in field trips

Parent's comments:

3. WATER ACTIVITIES I hereby ☐ give ☐ do not give -consent for my child to participate in water activities

☐ sprinkler play ☐ splashing/wading pool ☐ swimming pools ☐ water table play

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 ☐ Lunch ☐ PM snack

6. MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:

☐ Mondays	from:	to:
☐ Tuesdays	from:	to:
☐ Wednesdays	from:	to:
☐ Thursdays	from:	to:
☐ Fridays	from:	to:

Child daycare operations are public accommodations under the American 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).

Signature-Parent or Legal Guardian _____

Date _____

Emergency Contacts & Authorized Persons

1st Contact/Pick Up

Full Name

Relationship to Child Phone Number

Address/City/Zip

2nd Contact/Pick Up

Full Name

Relationship to Child Phone Number

Address/City/Zip

Signature- Parent or Legal Guardian

Signature- Parent or Legal Guardian Date

Signature - Parent or Legal Guardian Date

forms to include with this enrollment form
Admission information Form 2935 page 1 and 2

ADMISSION INFORMATION

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.

Name of sibling(s):

My child has permission to:

☐ ride the bus, and/or

☐ walk to or from school or home

☐ be released to the care of his/her sibling(s) under 18 years old.

IMMUNIZATION RECORD:

☐ I have provided the childcare operation of 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 chid is admitted to the child-care operation or within one week of admission.
Please check only one option:

1. ☐ HEALT-CARE PROFESSIONAL'S STATEMENT: I have examined the above name 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/ _____	☐ Pass ☐ Fail

SIGNATURE _____ DATE _____

HEARING	1000 Hz	2000 Hz	4000 Hz	☐ Pass ☐ Fail
R				
L				

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	3 mos	4 mos	5 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.

Signatue _____ Date _____

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) _____ and does not need a varicella vaccine.

Signature - Parent or Legal Guardian _____ Date _____

☐ I am excluding my child from 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 the Department of State Health Services at www.dshs.tx.us/immunize/public.shtm