



# Registration Form

If we can't read it, we can't enter it. **Please** print neatly!

Registration Date \_\_\_\_\_

Admission Date \_\_\_\_\_

Email to receive coupons and announcements. (Emails will not be shared.) \_\_\_\_\_

In lieu of picture identification at time of pick-up, please give us a password \_\_\_\_\_

**Guardians** Circle Relationship: Parent Grandparent Step-Parent Foster Parent Relative Friend

1 First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Home(\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_ Apt # \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Driver 's License \_\_\_\_\_ State \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

2 First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Home(\_\_\_\_) \_\_\_\_\_  
 Address if different \_\_\_\_\_ Apt # \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Driver 's License \_\_\_\_\_ State \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_  
 Children's Doctor Name/Phone \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
 Children's Dentist Name/Phone \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

**Emergency Contacts** Must list at least one contact other than parents as an Emergency Contact.

1 First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Home(\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_ Apt # \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Driver License # \_\_\_\_\_ State \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_  
 Circle Relationship: Parent Grandparent Step-Parent Foster Parent Relative Friend

**Other People Authorized for Pick-up**

1 \_\_\_\_\_ # \_\_\_\_\_ 2 \_\_\_\_\_ # \_\_\_\_\_

**Children** \*Health records are required to be on file according to Texas Dept of Family and Protective Services Child Care Licensing regulations. If your child's records are on file at another school or daycare, please indicate below. (If not, please have your child's doctor fill out the orange health form and return to KidsPark within one week of the date of your child's first visit.) Health records include immunization records, physician's health statement, and TB test and vision and hearing test if applicable.

**Children's Doctor's Name, address and phone** \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Name

First Name			
Last Name			
Sex	Boy Girl	Boy Girl	Boy Girl
Birth Date			
Child's Address if different than Primary Guardian			
Hygiene	Diapers Remind Trained	Diapers Remind Trained	Diapers Remind Trained
Health records are on file: School Address Phone			
1. Food allergies or restrictions?	Yes No	Yes No	Yes No
2. Other allergies?	Yes No	Yes No	Yes No
3. Takes medications?	Yes No	Yes No	Yes No
4. Asthma?	Yes No	Yes No	Yes No
5. Hearing/vision problems?	Yes No	Yes No	Yes No
6. Past health problems?	Yes No	Yes No	Yes No
7. Activity restrictions?	Yes No	Yes No	Yes No
8. Special care requirements?	Yes No	Yes No	Yes No

Explain any Yes answers. List by child's name and question number.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Registration will remain active unless there are no visits for 12 months.**



# ADMISSION INFORMATION

HEALTH REQUIREMENTS											
Name of Child: _____									Date of Birth: _____		
Age ▶ Vaccine ▼	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											
Pneumococcal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											
TB TEST (if required)		<input type="checkbox"/> Positive		<input type="checkbox"/> 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 _____											
<input type="checkbox"/> 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 <a href="http://www.dshs.state.tx.us/immunize/school_info.htm">http://www.dshs.state.tx.us/immunize/school_info.htm</a>											

**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. Please check only one option:

- 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
- 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 will submit it to the child-care operation.

Name and address of health care professional: \_\_\_\_\_

\_\_\_\_\_  
Signature - Parent or Legal Guardian Date

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

Signature – Parent or Legal Guardian

Date