Admission Form

Print Form

Facility Name: Bullfrogs and Butterflies Child Care Center Director's Name: Cindy Martin/ Kathy Kleppel

Child's Name | Date of Birth | Child's Home Telephone No.

Child's Address | City | State | Zip Code

Date of Admission | Date of Withdrawl | Hours and days child will be in care

Parent's or Guardian's Name | Street Address (if different from child's address) ☐ N/A

List telephone numbers where parents/guardian may be reached while child will be in care

Mother's Telephone No. Work | Cell | Email

Father's Telephone No. Work | Cell | Email

Guardian's Telephone No. Work | Cell | Email

Give the name, address and phone number of person to call in case of an emergency if parents/guardian cannot be reached:

Name | Address | City | State | Phone Number | Relationship

I hereby authorize the childcare facility to allow my child to leave the childcare facility ONLY with the following persons. (Name And Phone #)

Name: | Name: | Name:

Phone: | Phone: | Phone:

Check all that apply:

1. ☐ Transportation: I hereby ☐ Give ☐ Do Not Give - my consent for my child to be transported and supervised facility's employees:
2. ☐ Water Activities: I hereby ☐ Give ☐ Do Not Give - my consent for my child to participate in water activities
   ☐ Sprinkler Play ☐ Splashing/Wading Pools ☐ Swimming Pools ☐ Water Table Play
3. ☐ Field Trips: I hereby ☐ Give ☐ Do Not Give - my consent for my child to participate in field trips:

Parents Comments:

4. ☐ RECEIPT OF WRITTEN OPERATIONAL POLICIES

Parent Signature

I acknowledge receipt of the operational policies including those for discipline and guidance.

SCHOOL AGE CHILDREN

☐ My child attends the following school:

Name of School | Street Address | City | School PH #

CHECK ALL THAT APPLY:

☐ His/Her immunization record is on file at the school and all immunizations and tuberculosis test are current. Current Vision and Hearing screening recording are also on file.

☐ My child has permission to: ☐ Ride a bus ☐ walk to and from school, and/or ☐ be released to the care of his/her sibling(s) under 18 yrs. old

Name of Sibling(s):

Are there any special problems that your child may have, such as allergies, existing illnesses, previous serious illnesses, injuries during the past 12 months, any medications prescribed for long-term continuous use, and other information which staff show be aware of?

☐ NONE KNOWN ☐ YES, PLEASE LIST

Print Form

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the person in charge to take my child to:

Name of Physician:	Street Address:	City	State	Phone #

Name of Hospital:	Street Address:	City	State	Phone #

Parent(s) or Guardian Signature

I give consent for this facility to secure any and all necessary emergency medical care for my child:

Health Requirements

Name of Child

Date of Birth

IMMUNIZATION RECORD

☐ I have provided the childcare operation with a copy of my child's most current immunization record.

HEALTH STATEMENT

One of the following must be presented when your child (under the age of 5 years) is admitted to the day care facility or within one week of admission. Check to indicate the option you select:

☐ HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he/she is physically able to take part in the day care program.

Heath Care Professional's Signature: Date:

☐ A copy of the medical screening form of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, if no referral for further diagnosis and treatment is indicated.

☐ A form or written statement from a health service or clinic

If you do not have any of the above:

☐ PARENT'S STATEMENT: 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 statement and will submit it to the day care facility. My child was examined by:

Name of Health Care Professional

Address City State

Signature- Parent or Legal Guardian Date

VISION	R20/	L20/	☐ PASS ☐ FAIL

Signature Date

HEARING	1000 Hz	2000 Hz	4000 Hz	☐ PASS ☐ FAIL
R				
L				

Signature Date

NOTE: If medical diagnosis and treatment and/or immunization and TB testing conflict with your religious beliefs, you must sign an affidavit to that effect and attach it to this form. If Immunization and/ or TB testing would be injurious to your child or family, you must obtain a certificate (signed by a health care professional) to that effect and attach it to this form.

Signature- Parent or Legal Guardian Date