

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: Kyle's Bright Beginnings Learning Center	Director's Name: Stacey Dees	
Child's Full Name:	Child's Date of Birth:	Child Lives With? <input type="radio"/> Both Parents <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Guardian
Child's Home Address:	Date of Admission:	Date of Withdrawal:
Name of Parent or Guardian Completing Form:	Address of Parent or Guardian (if different from the child's):	

Provide contact information below where parents or guardian may be reached while child is in care.

Parent 1 Name: Email address: Phone number:	Parent 2 Name: Email address: Phone number:
Guardian Name: Email address:	Phone number: Custody Documents on File? Yes No

In case of an emergency, call:

Name of Emergency Contact:	Relationship:	Area Code and Phone No.:
Address:		
I authorize the childcare operation to release my child to leave the childcare operation ONLY with the following persons. Please list the 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). <input type="checkbox"/> for emergency care <input type="checkbox"/> on field trips <input type="checkbox"/> to and from home <input type="checkbox"/> to and from school
2. Field Trips:
<input type="checkbox"/> I give consent for my child to participate in field trips. <input type="checkbox"/> I DO NOT give consent for my child to participate in field trips.
Additional Comment:
3. Water Activities:
I give consent for my child to participate in the following water activities (Check all that apply). <input type="checkbox"/> water table play <input type="checkbox"/> sprinkler play <input type="checkbox"/> splashing or wading pools <input type="checkbox"/> swimming pools <input type="checkbox"/> aquatic playgrounds
Is your child able to swim without assistance? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, what type of assistance is needed?
4. Receipt of Written Operational Policies:
I acknowledge receipt of the facility's operational policies, including those for: (Check all that apply)
<input type="checkbox"/> Discipline and Guidance <input type="checkbox"/> Procedures for release of children
<input type="checkbox"/> Suspension and expulsion <input type="checkbox"/> Illness and exclusion criteria
<input type="checkbox"/> Emergency plans <input type="checkbox"/> Procedures for dispensing medications
<input type="checkbox"/> Procedures for conducting health checks <input type="checkbox"/> Immunization requirements for children
<input type="checkbox"/> Safe sleep <input type="checkbox"/> Meals and food service practices
<input type="checkbox"/> Procedures for parents to discuss concerns with the director <input type="checkbox"/> Procedures to visit the center without securing prior approval
<input type="checkbox"/> Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions <input type="checkbox"/> Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website
<input type="checkbox"/> Procedures for parents to participate in operation activities <input type="checkbox"/> Procedures for supporting inclusive services

5. Meals:			
I understand that the following meals will be served to my child while in care (Check all that apply):			
<input type="checkbox"/> None <input type="checkbox"/> Breakfast <input type="checkbox"/> Morning snack <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening snack			
6. Days and Times in Care:			
Day of the Week	A.M.	P.M.	My child is normally in care on the following days and times:
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			
Child's Special Care Needs (check all that apply)			
<input type="checkbox"/> Environmental allergies		<input type="checkbox"/> Limitations or restrictions on child's activities	
<input type="checkbox"/> Food intolerances		<input type="checkbox"/> Reasonable accommodations or modifications	
<input type="checkbox"/> Existing illness		<input type="checkbox"/> Adaptive equipment (<i>include instructions below</i>)	
<input type="checkbox"/> Previous serious illness		<input type="checkbox"/> Symptoms or indications of complications	
<input type="checkbox"/> Injuries and hospitalizations (<i>past 12 months</i>)		<input type="checkbox"/> Medications prescribed for continuous long-term use	
<input type="checkbox"/> Other:			
Explain any needs selected above:			
Does your child have diagnosed food allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No Food Allergy Emergency Plan Submitted Date: _____			
Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title 111 . To learn more, visit https://www.ada.gov/resources/child-care-centers/ . If you believe that such an operation may be practicing discrimination in violation of Title 111, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).			
Signature of Parent / Legal Guardian: _____		Date : _____	
Signature of Center Designee: _____		Date : _____	

School Age Children
My child attends the following school:
School Area Code and phone No.:
My child has permission to (check all that apply) :
<input type="checkbox"/> Walk to or from school <input type="checkbox"/> ride a bus <input type="checkbox"/> be released to the care of his or her sibling under 18 years old
Authorized pick up or drop off locations other than the child's address:
<input type="checkbox"/> 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:												
<table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;">Name of Physician:</td> <td style="width:33%; border: none;">Address</td> <td style="width:33%; border: none;">Phone number:</td> </tr> <tr> <td style="border: none;"> </td> <td style="border: none;"> </td> <td style="border: none;"> </td> </tr> <tr> <td style="border: none;">Name of Emergency Care Facility:</td> <td style="border: none;">Address</td> <td style="border: none;">Phone number:</td> </tr> <tr> <td style="border: none;"> </td> <td style="border: none;"> </td> <td style="border: none;"> </td> </tr> </table>	Name of Physician:	Address	Phone number:				Name of Emergency Care Facility:	Address	Phone number:			
Name of Physician:	Address	Phone number:										
Name of Emergency Care Facility:	Address	Phone number:										
I give consent for the facility to secure all necessary emergency medical care for my child.												
<table style="width:100%; border: none;"> <tr> <td style="width:60%; border: none;">Signature – Parent or Legal Guardian _____</td> <td style="width:40%; border: none;">Date Signed _____</td> </tr> </table>	Signature – Parent or Legal Guardian _____	Date Signed _____										
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/	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	
_____	_____			_____
Signature		Date Signed		

Hearing Exam Results

Ear	1000Hz	2000 Hz	4000Hz	Pass or Fail
Right				<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Left				<input type="checkbox"/> Pass <input type="checkbox"/> Fail
_____		_____		
Signature		Date Signed		

Admission Requirement

If your child does not attend pre-kindergarten or school away from the childcare operation, one of the following must be presented when your child is admitted to the childcare operation or within one week of admission. (Select only one option below.)

- Health Care Professional's Statement: I have examined the above names child within the past year and find that he or she is 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 childcare program 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

Vaccine Information		
The following vaccines require multiple doses over time. Please provide the date your child received each dose.		
Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (1 st dose)	
	1-2 months (2 nd dose)	
	6-18 months (3 rd dose)	
Rotavirus	2 months (1 st dose)	
	4 months (2 nd dose)	
	6 months (3 rd dose)	
Diphtheria, Tetanus, Pertussis	2 months (1 st dose)	
	4 months (2 nd dose)	
	6 months (3 rd dose)	
	15-18 months (4 th dose)	
	4-6 years (5 th dose)	
Haemophilus Influenza Type B	2 months (1 st dose)	
	4 months (2 nd dose)	
	6 months (3 rd dose)	
	12-15 months (4 th dose)	
Pneumococcal	2 months (1 st dose)	
	4 months (2 nd dose)	
	6 months (3 rd dose)	
	12-15 months (4 th dose)	
Inactivated Poliovirus	2 months (1 st dose)	
	4 months (2 nd dose)	
	6-18 months (3 rd dose)	
	4-6 years (4 th 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 (1 st dose)	
	4-6 years (2 nd dose)	
Varicella	12-15 months (1 st dose)	
	4-6 years (2 nd dose)	
Hepatitis A	12-23 months (1 st dose)	
	The 2 nd dose should be given 6 – 18 months after the 1 st dose.	
Varicella (Chickenpox)		
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.		
Signature _____ Date signed: _____		
Additional Information Regarding Immunizations		
For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm		
TB Test (If Required)		
<input type="checkbox"/> Positive <input type="checkbox"/> Negative Date : _____		
Gang Free Zone		
Under the Texas Penal Code, any area within 1,000 feet of a childcare 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		
Physician or Public Health Personnel Verification		
Signature or stamp of a physician or public health professional verifying immunization information above.		
Signature: _____ Date Signed: _____		
Signatures		
Child's Parent or Legal Guardian : _____ Date Signed: _____		
Center Designee: _____ Date Signed: _____		

CONSENT TO VIDEO/PHOTOGRAPH RELEASE for KBB Promotional Website and Social Media

<p>I understand that my child’s voice, physical presence, and participation in classroom activities may be photographed and/or video recorded will not be a violation of his/her personal rights. I hereby release any claims for such use during the duration of his/her enrollment at Kyle’s Bright Beginnings Learning Center.</p>	<p><input type="checkbox"/> I DO give my consent.</p> <p><input type="checkbox"/> I DO NOT give my consent.</p> <p>Student’s Name: _____</p>
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Signature of Parent/ Guardian: _____ Date Signed: _____

TUITION POLICY AGREEMENT

I understand that tuition is due on Friday prior to the week of service, or period of service. I understand that any appropriate tuition and/or fees will be invoiced to my brightwheel account and automatically paid through the Auto-pay function in brightwheel, which is required. I will link either a Credit Card, Debit Card, or Bank Account to my brightwheel account and make sure that there are adequate funds available to pay the tuition/fees when due. If any payments are returned I will have until the next business day to necessary adjustments to have the tuition/fees amount ready for Auto-pay withdrawal. If not corrected, I understand that a \$35.00 Return Payment fee will be added to my brightwheel account. If not corrected within 3 business days, my child will not be allowed to attend until tuition is paid. After five days of delinquency, my child will be withdrawn from KBB.

If there is a valid reason AutoPay cannot be used for tuition payment, an alternative payment method can be arranged with prior mutual agreement between me and KBB management.

I understand that any amount owed to KBB will be subject to legal collection proceedings through civil or criminal court as appropriate and I will be responsible for any collection costs incurred.

Parent /Guardian Signature: _____ Date: _____

LATE PICK-UP CHARGES

Late pick-up fees are **\$15.00** for anytime between 6:30 pm and 6:35 pm per child, **PLUS \$1.00** for every minute thereafter per child.

VACATION DISCOUNT

Vacation discounts are allowed twice per year. I acknowledge that I have two (2) weeks of vacation absences per year per KBB’s Vacation Request Guidelines below:

1. Submit a written notice of request for any given week (Monday – Friday) at least two weeks prior to vacation request period.
2. Pay a \$100.00 administrative fee with the written request notice.
3. I acknowledge that when using a vacation week, my child WILL NOT be in the care of KBB for the entire week.

Parent /Guardian Signature: _____ Date: _____