



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 Heaven Little Angels Academy		Director's Name Claudia Marquez	
Child's Full Name	Child's Date of Birth	Child Lives With <input type="radio"/> Both parents <input type="radio"/> Mom <input type="radio"/> Dad <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)	
List telephone numbers below where parents/guardian may be reached while child is in care.			
Parent 1 Telephone No.	Parent 2 Telephone No.	Guardian's Telephone No.	Custody Documents on File <input type="radio"/> Yes <input type="radio"/> No
Give the name, address, and phone number of the responsible individual to call in case of an emergency if parents/guardian cannot be reached			Relationship
I authorize the child care operation to release my child to leave the child care operation ONLY with the following persons. Please list name and telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID.			
Name		Phone Number	
Name		Phone Number	
Name		Phone Number	

Consent Information

Check All That Apply:			
1. Transportation			
I give consent for my child to be transported and supervised by the operation's employees:			
<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="radio"/> I give consent for my child to participate in field trips.			
<input type="radio"/> I do not give consent for my child to participate in field trips.			
Comments			

3. Water Activities

I give consent for my child to participate in the following water activities:

- ☐ water table play ☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ aquatic playgrounds

4. Receipt of Written Operational Policies (Check All that Apply)

I acknowledge receipt of the facility's operational policies, including those for:

- | | |
|--|---|
| <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"/> Procedures for parents to participate in operation activities | <input type="checkbox"/> Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website |

5. Meals

I understand that the following meals will be served to my child while in care:

- ☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. Days and Times in Care

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

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 Number
Name of Emergency Care Facility	Address	Phone Number

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

Signature — Parent or Legal Guardian

Child's Additional Information Section

List any special needs that your child may have, such as environmental allergies, food intolerances, 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 caregivers should be aware of:

Does your child have diagnosed food allergies? ☐ Yes ☐ No Plan Submitted on _____

Child day care operations are public accommodations under the Americans 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 Signed

School Age Children

My child attends the following school

School Phone Number

My child has permission to (check all that apply):

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his/her sibling under 18 years old

Authorized pick up/drop off locations other than the child's address

☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

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.

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 or she is able to take part in the day care program.

Signature — Health Care Professional

Date Signed

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 submit it to the child care operation.

Name

Address of Health Care Professional

Signature — Parent or Legal Guardian

Date Signed

Requirements for Exclusion

- ☐ 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/ ☐ Pass ☐ Fail

Signature

Date Signed

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				<input type="radio"/> Pass <input type="radio"/> Fail
Left				<input type="radio"/> Pass <input type="radio"/> Fail

Signature

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 (first dose)	
	1-2 months (second dose)	
	6-18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15-18 months (fourth dose)	
	4-6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12-15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Inactivated Poliovirus	12-15 months (fourth dose)	
	2 months (first dose)	
	4 months (second dose)	
	6-18 months (third dose)	
	4-6 years (fourth 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 (first dose)	
	4-6 years (second dose)	
Varicella	12-15 months (first dose)	
	4-6 years (second dose)	
Hepatitis A	12-23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature

Date Signed

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)

☐ Positive ☐ Negative Date: _____

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care 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>

Signatures

Child's Parent or Legal Guardian

Date Signed

Center Designee

Date Signed

Photo Release Form

Please be advised that your child may be photographed or video taped at various school sponsored events. If you would like your child's photo to appear in our class website or Shutterfly, please sign and return this form.

Please sign and return this form.

_____ **Yes,** I give permission for my child's photograph and or video to be posted on our class website.

_____ **No,** my child's photograph and/or video may not be posted on the website.

(Signature)

(Date)

(Student's First and Last Name)

Discipline and Guidance Policy for Heaven Little Angels

Name of Operation

- ◆ Discipline must be:
 - (1) Individualized and consistent for each child;
 - (2) Appropriate to the child's level of understanding; and
 - (3) Directed toward teaching the child acceptable behavior and self-control.
- ◆ A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:
 - (1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
 - (2) Reminding a child of behavior expectations daily by using clear, positive statements;
 - (3) Redirecting behavior using positive statements; and
 - (4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.
- ◆ There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:
 - (1) Corporal punishment or threats of corporal punishment;
 - (2) Punishment associated with food, naps, or toilet training;
 - (3) Pinching, shaking, or biting a child;
 - (4) Hitting a child with a hand or instrument;
 - (5) Putting anything in or on a child's mouth;
 - (6) Humiliating, ridiculing, rejecting, or yelling at a child;
 - (7) Subjecting a child to harsh, abusive, or profane language;
 - (8) Placing a child in a locked or dark room, bathroom, or closet with the door closed;and
 - (9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Texas Administrative Code, Title 40, Chapters 746 and 747, Subchapters L, Discipline and Guidance

My signature verifies I have read and received a copy of this discipline and guidance policy.

Signature _____

Date _____

Check one please:

☐ parent

☐ employee/caregiver

☐ household member of child-care home

Heaven Little Angels Academy

Receipt of Acknowledgement

PLEASE READ, INITIAL, SIGN AND DATE THE LAST PAGE OF THIS HANDBOOK AND RETURN IT TO THE DIRECTOR.

1. I have read and understand this handbook of the policies & procedures. I also understand that this is a legally-binding contract. _____
2. I agree to abide by all policies and procedures listed _____
3. I understand that changes can and will be made at anytime with notice. _____
4. I will report any and all changes in writing to the Director. _____
5. If I agree to follow all stipulation outline in this handbook. Failure to follow procedures could jeopardize my child's enrollment. _____
6. I agree to pay the contracted amount explained by the Director and signed by me _____
7. I agree to the scheduled pick up times explained by the Director and signed by me _____
8. I understand that this is a legal contract and can be used against me in a court of law _____

Child's Name in care

Date of Birth

Sibling's Name in care

Date of Birth

Parent's Signature

Date

Heaven Little Angels Academy Personnel Signature Date

Director's Signature

Date

CACFP STUDENT ENROLLMENT

CM-1500

Heaven Little Angels Academy

participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to annually review and make changes to enrollment data.

CHILD INFORMATION

Center Enroll Date: / /

Child's First Name:

Child's Last Name:

Child's Birth Date: / /

Normal Days in Care
Center's Days of Operation: -M-F
M T W TH F SA SU

Normal Hours in Care
Center's Hours of Operation: -05:30 AM-06:30 PM
 AM to AM PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: -BRK, LUN, PMS
BRK AMS LUN PMS SUP EVS

Ethnic Identity (Check One)
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
☐ White
☐ Black / African American
☐ Am. Indian / Alaskan Native
☐ Asian
☐ Native Hawaiian / Other Pacific Islander

Gender
☐ Male
☐ Female

SITE / SPONSOR USE ONLY

Withdrawal Date: / /
Re-Enroll Date: / /

Center Enroll Date: / /

Child's First Name:

Child's Last Name:

Child's Birth Date: / /

Normal Days in Care
Center's Days of Operation: -M-F
M T W TH F SA SU

Normal Hours in Care
Center's Hours of Operation: -05:30 AM-06:30 PM
 AM to AM PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: -BRK, LUN, PMS
BRK AMS LUN PMS SUP EVS

Ethnic Identity (Check One)
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
☐ White
☐ Black / African American
☐ Am. Indian / Alaskan Native
☐ Asian
☐ Native Hawaiian / Other Pacific Islander

Gender
☐ Male
☐ Female

SITE / SPONSOR USE ONLY

Withdrawal Date: / /
Re-Enroll Date: / /

Center Enroll Date: / /

Child's First Name:

Child's Last Name:

Child's Birth Date: / /

Normal Days in Care
Center's Days of Operation: -M-F
M T W TH F SA SU

Normal Hours in Care
Center's Hours of Operation: -05:30 AM-06:30 PM
 AM to AM PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: -BRK, LUN, PMS
BRK AMS LUN PMS SUP EVS

Ethnic Identity (Check One)
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
☐ White
☐ Black / African American
☐ Am. Indian / Alaskan Native
☐ Asian
☐ Native Hawaiian / Other Pacific Islander

Gender
☐ Male
☐ Female

SITE / SPONSOR USE ONLY

Withdrawal Date: / /
Re-Enroll Date: / /

PARENT / GUARDIAN INFORMATION

I certify the information on this form is true and correct to the best of my knowledge and that I have received access to WIC and CACFP literature within the last 12 months.

Signature

Date

Parent First Name

Parent Last Name

Cell Phone

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Non - Discrimination Statement

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.



Center Name _____

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)**Part 1. All Household Members****Name of Enrolled Child(ren):** _____**Names of all household members**
(First, Middle Initial, Last)CHECK IF A FOSTER CHILD (THE
LEGAL RESPONSIBILITY OF A
WELFARE AGENCY OR COURT)
* IF ALL CHILDREN LISTED BELOW
ARE FOSTER CHILDREN, SKIP TO
PART 5 TO SIGN THIS FORM.CHECK
IF NO INCOME**Part 2. Benefits:** If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME: _____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number: NAME _____ ELIGIBILITY NUMBER: _____Check here if no eligibility number ☐**Part 4. Total Household Gross Income—You must tell us how much and how often**

A. Name (List only household members with income) (Example) Jane Smith	B. Gross income and how often it was received Note: Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	\$200/weekly	\$150/twice a month	\$100/monthly	\$200/bi-monthly
	\$____/____	\$____/____	\$____/____	\$____/____
	\$____/____	\$____/____	\$____/____	\$____/____
	\$____/____	\$____/____	\$____/____	\$____/____
	\$____/____	\$____/____	\$____/____	\$____/____
	\$____/____	\$____/____	\$____/____	\$____/____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)*I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: * * * - * * - _____ ☐ I do not have a Social Security Number