Discovery Years, Inc.

Admission Form

Date: _____

Childs Name: _____ Birthday: _____

Address: _____

_____

Parent Information

Mother's Name: _____ Home Phone: _____

Occupation: _____ Cell No: _____

Place of Employment: _____ Email: _____

TX DL# _____

Father's Name: _____ Home Phone: _____

Occupation: _____ Cell No: _____

Place of Employment: _____ Email: _____

TX DL# _____

Child's Medical Information

Family Physician: _____ Work No: _____

Address: _____ City: _____ TX. _____ Zip: _____

Preferred Hospital: _____ Phone No: _____

Medical Insurance Co.: _____ Policy No. _____

Known Allergies: _____

Other Medical Conditions: _____

Medical Release

In the event of sudden illness or an accident, and time does not permit me to make arrangements for emergency medical attention for my child, I authorize Discovery Years, Inc. and its director/or a designee to take my child to the nearest emergency room, doctor's office or hospital.

I hereby give consent for emergency treatment when my child is in the care of a physician, emergency room, or hospital.

_____ _____

Date **Parent/Guardian Signature**

I hereby authorize Discovery Years, Inc. to allow my child to leave the daycare facilities ONLY with:

_____ _____

_____

Parent/Guardian Signature

Water Activities

_____ has my permission to participate in the water activities, (1.e. sprinklers, water tables, wading pools, etc.)

_____ _____

Parent/Guardian Signature Date

Transportation

In case of an emergency, Discovery Years, Inc. has my permission to transport

_____.

_____ _____

Parent/Guardian Signature Date

Special Summer Activities

_____ has my permission to participate in special activities at Discovery Years, Inc. (i.e. train ride, camel ride, petting zoo, pony ride, etc.).

_____ _____

Parent/Guardian Signature Date

First Aid

Discovery Years, Inc. has my permission to apply Neosporin or Hydrogen Peroxide to my child

_____ for scrapes, bites, etc.

_____ _____

Parent/Guardian Signature Date

Permission to Photograph

Discovery Years, Inc. has my permission to photograph my child _____

for display purposes, (i.e. scrapbooks, bulletin boards, website, posts, other).

_____ _____

Parent/Guardian Signature Date

Texas Dept of Family and Protective Services

ADMISSION INFORMATION

Form 2935
Aug 2010 / Pg 1 of 3

Operation Name		Director's Name	
Child's Full Name		Child's Date of Birth	Child's Home Telephone No.
Child's Home Address			
Date of Admission	Date of Withdrawal		
Parent's or Guardian's Name		Address (if different from child's address)	

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

Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.	Cell Phone No

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

I hereby authorize the childcare operation to allow my child to leave the childcare operation ONLY with the following persons. Please list name & telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.

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 employees:
   Walk home ☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school
2. ☐ **FIELD TRIPS:** I hereby ☐ give ☐ do not give – my consent for my child to participate in Field Trips:
   Parent's Comments:
3. ☐ **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
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:**
   ☐ None ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening 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:
☐ Saturdays	from:	to:
☐ Sundays	from:	to:

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:	Ph.#:
Name of Emergency Medical Care Facility:	Address:	Ph.#:

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

_____
Signature - Parent or Legal Guardian

List any special problems 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 which caregiver's should be aware of:

_____

_____

Child daycare 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

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:
☐ walk to or from school or home,
☐ ride a bus, and/or
☐ be released to the care of his/her sibling(s) under 18 years old.

IMMUNIZATION RECORD:

☐ I have provided the childcare operation with 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 child is admitted to the child-care operation or within one week of admission.

Please 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 / 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	
R				☐ PASS ☐ FAIL
L				
SIGNATURE _____		DATE _____		

_____ _____
Signature – Parent or Legal Guardian Date

Photo Release Form for Minors

Discovery Years Early Learning Center Fry
7020 Fry Rd.
Cypress, TX 77433

I, being the parent/guardian of _____, hereby consent that the photographs or videos taken of him/her during child care while he/she is enrolled at ***Discovery Years Early Learning Center*** as a student may be used by ***Discovery Years Early Learning Center***.

These pictures may be used in slideshows, emails, bulletin boards, preschool brochures, church/school website (www.discoverycypress.com), Preschool Facebook page, etc. When any pictures of students do appear on the web site there will not be any personal identification (i.e., student name).

Furthermore, I consent that such photographs and or videos shall be the property of ***Discovery Years Early Learning Center*** which has the right to duplicate, reproduce, and make other uses as ***Discovery Years Early Learning Center*** deems necessary.

☐ I give my permission to use my son/daughter's photograph, etc. AS DESCRIBED ABOVE.

☐ I give my permission for my child's picture to be used in slideshows and emails only.

☐ I DO NOT give my consent to have photographs of my son/daughter used by *Discovery Years Early Learning Center* IN ANY WAY, as specified above.

Name of Student _____ DOB _____

Signature of Parent _____

Street Address _____

City, State, ZIP _____ Phone _____

Please sign and return this to the Preschool office. This form will be kept on file in the student's permanent record in the Preschool office. Parents may update or make changes to this form at any time.

NEW ☐ **UPDATE** ☐ **DROP IN** ☐

Institution Name: Anita Moreau Food Program Specialist Agreement Number: _____

Facility/Provider Name: Discovery Years Learning Center - Addicks 008

Child and Adult Care Food Program (CACFP)

Participant Enrollment Form

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian Please Complete:

Participant's (Child) Name: _____ Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female Date participant enrolled in the facility: _____

Food Allergies: ☐ Yes ☐ No If "yes" specify: _____

(If the participant cannot be served the CACFP Meal Pattern, a statement from the participant's Health Care Provider must be provided.)

Check Days of Normal Care at facility: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Check meals normally eaten at facility: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Please list the normal times of arrival and departure (check am or pm): **Arrive:** _____ ☐ am ☐ pm **Depart:** _____ ☐ am ☐ pm

RACE OF PARTICIPANT: You are NOT required to answer this question.

☐ White ☐ Black or African American ☐ America Indian/Alaska Native

☐ Asian ☐ Native Hawaiian or Other Pacific Islander

ETHNIC IDENTITY: You are NOT required to answer this question.

☐ Hispanic or Latino ☐ Not Hispanic or Latino

If participant is an infant (0-11 months), please complete this box, Check all applicable choice(s) below:

This institution/facility offers _____ formula for infants through CACFP. It is your choice
(To be completed by facility/provider)

whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.

Please mark your preference (choose all that apply)	Today's Date Birth - 5 months	Today's Date 6 - 11 months
I will bring expressed breastmilk for my infant.		
I want the provider to provide the infant formula for my infant.		
I will bring the infant formula for my infant. Please list the kind of infant formula you will bring.		

According to CACFP requirements, in order to claim meals for reimbursement, the provider must provide infant cereal and other foods when your infant is developmentally ready to accept them.

Please mark your preference	Today's Date 6 - 11 months
I want the provider to provide the infant cereal and other foods for my infant.	
I will bring the infant cereal and/or other foods for my infant.	
My child is NOT developmentally ready for solid foods. I will inform the provider when and designate the solid food(s) to be introduced to my infant at that time.	

Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider.

I hereby certify the information given on this sheet is true and correct to the best of my knowledge. I also certify that I was given CACFP Meal Benefits Income Eligibility Form Letter to Household, the WIC information, Building for the Future Flyers, Civil Rights Appeals Procedures.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____ Date Dropped: _____

Work Telephone Number: _____ Emergency Telephone Number: _____

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 case number ❑

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List only household members with income)	**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
(Example) *Jane Smith*	$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

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income:_____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____

Categorical Eligibility:____ Date Withdrawn: _____ Eligibility: Free____ Reduced____ Denied ___ Tier I____ Tier II ____

Reason:_____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

Privacy Act Statement:

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
This institution is an equal opportunity provider.

(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov

Workforce Solutions

Parent Orientation Checklist

Name of child: _____

Name of parent/guardian: _____

- ☐ Opportunity to tour the facility
- ☐ Introduction to the staff
- ☐ Parent visit with the classroom caregiver
- ☐ Overview of the parent handbook
- ☐ Policy for arrival and late arrival
- ☐ Opportunity for an extended visit in the classroom by both myself and my child for a period of time to allow us both to be comfortable
- ☐ Explanation of the Texas Rising Star Program
- ☐ Encouragement to share elements of my CCS enrollment so that the provider may assist, if applicable
- ☐ Family support resources and activities in the community
- ☐ Child development and developmental milestones

Expectations of families:

- ☐ The significance of consistent arrival time, including:
  - -before the educational portion of the school begins
  - -impact of disrupting other children's' learning
  - -the importance of consistent routines in preparing children for the transition to Kindergarten
- ☐ Statement about limiting technology use on site to improve communication between staff, children and families
- ☐ Statement reflecting the role and influence of families

I acknowledge that I have received the information above.

_____

Parent/Guardian Signature Date

_____

Staff Signature Date

Discovery Years, Inc. Policies and Guidelines

Parent's Acknowledgement

This is to acknowledge that I have been provided with a copy of Discovery Years Inc.'s Policies and Guidelines

_____ _____

(Signature-Parent) (Date)

_____

(Child's Name)

_____

(Child's Name)

_____

(Child's Name)

Discovery Years
Early Learning Center

Doctor's Statement

_____
Child's Name

I have examined the above named child within the past 12 months and have found him/her to be in good health, and free from any contagious disease. He/she may participate in all group activities.

Physician's Name: _____

Address: _____

Phone: _____

_____ _____
Physician's Signature **Date**

Emergency Preparedness Plan

Discovery Years Early Learning Center
6847 Addicks Satsuma Rd.
Houston, Texas 77084

When Fire Alarm Sounds

Teachers must take their classroom roll sheets and all of their students to the fence at the rear of the property. Each teacher is then responsible for taking roll for their class. Once all children are accounted for, teachers and students should stay put, and wait for further instructions. When the "all clear" signal is given, everyone may re-enter the building, and report back to their respective classroom.

Emergency Evacuation Plan

If relocation is needed in an emergency situation such as fire, flood, toxic fumes, etc...
The first responsibility of staff is to move children to a designated safe area.

Designated safe area:
Discovery Years
7020 Fry Rd.
Cypress, Texas 77433
281-861-8755

Teachers will take children to the barn area and shut the gate behind them. Teachers will supervise children until buses arrive. Teachers will kick out a few boards in the fence so children can be loaded one at a time onto a bus. Roll will be taken to make sure all children are accounted for. Information for notifying parents and child care licensing will be found in the emergency preparedness binder. Teachers are responsible for keeping children safe and calm.

In Case of Inclement Weather

Teachers must take their classroom roll sheets and all of their students to the hall nearest their room. Students should be instructed to sit, facing either wall (north or south), with their heads in their laps, and their hands over their heads. Each teacher is then responsible for taking roll for their class. Once all children are accounted for, the teachers should assume the same sitting position as the children, and wait for further instructions. When the "all clear" signal is given, everyone may report back to their respective classrooms.

_____ _____

Signature of employee Date

CLASSROOM SUPPLY LIST

MARKERS	2 PKG.'S
CRAYONS – JUMBO OR LG	2 PKG.'S
GLUE	2 BOTTLES
KLEENEX	2 BOXES
BABY WIXPES – 80 COUNT	2 PKG.'S
PLAY DOUGH – QTY 4	1 PACK
GALLON ZIPLOCK BAGS	2 PKG.'S

CLOTHES

ALL CHILDREN SHOULD HAVE A FULL CHANGE OF CLOTHES IN THEIR CUBBIES. PLEASE PLACE CLOTHES IN A GALLON SIZE ZIPLOCK BAG WITH CHILD'S FULL NAME PRINTED ON CLOTHING ITEMS AND ON THE BAG.

DIAPERS

CHILDREN STILL IN DIAPERS NEED TO SUPPLY:

*DIAPERS

*TWO 80 COUNT BOXES OF BABY WIPES AT THE BEGINNING OF EACH MONTH.

BLANKETS

DISCOVERY YEARS WILL PROVIDE EACH CHILD WITH A MAT AND BLANKET.