

Registration Packet



Burleson ISD Child Care
421 Jayellen
Burleson, TX 76028

817-245-1250 phone
817-245-1270 fax

Please return the attached paperwork
along with a copy of the most recent
shot record.

(Updated 7/2019)

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Burleson ISD Child Care
421 Jayellen
Burleson, TX 76028
817-245-1250

Date of Enrollment _____

Parent Signature _____

Burleson ISD Child Care Registration Form

Student Information

Child's Name _____
(First, Middle, Last)

Date of Birth: _____
(Month/Day/Year)

Sex : _____ Age _____ Age Sept. 1st _____

Child's Name _____
(First, Middle, Last)

Date of Birth: _____
(Month/Day/Year)

Sex : _____ Age _____ Age Sept. 1st _____

Child's Name _____
(First, Middle, Last)

Date of Birth: _____
(Month/Day/Year)

Sex : _____ Age _____ Age Sept. 1st _____

Who has legal custody of the child(ren) being enrolled? _____

Home Address: _____

Mailing Address (if different from above): _____

Custody Documents in file: _____ Yes _____ No

Mother's Name: _____ Father's Name: _____

Home Address: _____ Home Address: _____

Home Phone: _____ Home phone: _____

Cell: _____ Cell: _____

E-mail: _____ E-mail: _____

Employer: _____ Employer: _____

Campus: _____ Campus: _____

Occupation: _____ Occupation: _____

Work Phone: _____ Work Phone: _____

Drivers License. No.: _____ Drivers License. No. _____

Third Party Emergency Contact: (If we can't get hold of parents)

Name: _____ Relationship: _____

Address: _____

Phone Number: _____

Secondary Contact/Release of Child

In case you need to be contacted during the day, please list the order of who to contact:

1st Contact Person

Name: _____

Phone #1: _____

Phone #2: _____ Specific Instruction: _____

2nd Contact Person

Name: _____

Phone #1: _____

Phone #2: _____ Specific Instruction: _____

3rd Contact Person

Name: _____

Phone #1: _____

Phone #2: _____ Specific Instruction: _____

I authorize Burleson ISD Child Care to release my child to the following people **not listed above** that they may pick up my child from daycare.

Name	Relationship	Phone	Drivers License No.
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____

Who is the employee of the Burleson ISD? _____

What campus is this person at? _____

Campus phone number: _____

Child Information

Days child will be in Burleson ISD Child Care :(Circle) M T W TH F

Hours child will be in care: from _____ to _____

Parents are: Married ___ Divorced ___ Separated ___ Widowed ___

Child lives with: Both parents ___ Mother ___ Father ___ other ___

(if other, please list) _____

If divorced or separated, state custody arrangements: (copy of court records required) _____

Nick name or preferred name of child: _____

Language spoken at home: English other: _____

Preferred form of comfort (stuffed animal, rocking, etc.) _____

Fears: _____

Was child premature? _____

Is the child potty trained? _____

Child's preferred way of sleeping/going to sleep:

How long does he/she sleep? _____

Child's previous group experience: _____

Existing illness: _____

Hospitalizations: _____

Serious illnesses or injuries: _____

Special screenings for motor development: _____

Special screenings for developmental delay: _____

Please list siblings and ages:

1) _____

2) _____

3) _____

All immunizations up to date? ___ (a copy of shot record required)

Is child free from all communicable diseases? _____

Food Allergies: _____

Allergy Action Plan on file? Y or N Date submitted _____

Other Allergies: _____

Has your child had Chickenpox? Approximate date: _____

Long Term Medications:

Name of medicine Dosage amount Dosage time

Signature of Parent

Date

Consent and Release, Parent Affidavit, Media Release, Water Play Permission

- A.** Child's full name: _____
- B.** In the event of an emergency, we will call 911. I authorize the facility director or person in charge to take my child to:
Hospital preference if condition so indicates _____
Personal Insurance Company _____ Medicaid Yes ___ No ___
Authorization for Doctor's Care Yes ___ No ___ Doctor _____
Phone _____ Dr. Address _____
- C.** I ___ do ___ do not give my consent for this facility to secure any and all necessary emergency medical care for my child.
- D. Parent Affidavit:** Please complete which of the following applies to your child:
- a. My child has been examined within the last 12 months by our physician, _____, located at _____ and is able to participate in the activities of the Burleson ISD Child Care without health repercussions.
 - b. I ___ do ___ do not decline immunizations. (Affidavit needed)
- E.** I will also provide Burleson ISD Child Care a signed, written statement (Health Form) from our physician **within 1 week of enrollment.**
- F.** I ___ do ___ do not allow my child to be screened for Vision and Hearing when they are in the Pre-K class. (Affidavit needed if answered "no")
- G. Media Release:** I do ___ do not ___ give Burleson ISD Child Care permission to take and post pictures of my child as is best suited for the Public Relations of the Burleson ISD Child Care and Burleson Independent School District. **(Child's name is never used)**
- H. Water Play:** I give permission for my child to participate in water activities at the Burleson ISD Child Care. I understand the water activity could include water table play, squirt guns, splash pool (last week of school only), fishing activity (small tubs of water), sprinkler play, etc. There will be NO pool larger than a child's wading pool used and all water play will be highly supervised. (This is for the older children)

Parent Signature

Date

Medical Release & Document Acknowledgement

_____ I give permission for the Burleson ISD Child Care staff to use the following on my child during diaper changes:

_____ cream _____ ointment _____ lotion

_____ I do not want any, cream, ointment, or lotion applied to my child during diaper changes.

_____ I give permission for the Burleson ISD Child Care staff to use over-the-counter medication as necessary for minor medical problems.

_____ I understand I have to provide and leave any medication to be used; the daycare cannot provide any.

_____ I do not want the use of any over-the-counter medication administered to my child.

_____ I give BISD Child Care permission to use the following on my child at their discretion:

_____ Neosporin

_____ Hydrocortisone

_____ I do NOT give BISD Child Care permission to use the above medications on my child.

Child's Name _____

Parent Signature

Date

Document Acknowledgement

I hereby acknowledge that I understand there is a copy of the following documents available on the Burleson ISD/Childcare website. I understand I can access this and should I have any questions I can get with Burleson ISD Child Care staff. I also understand I can receive a printed copy should I request it.

Policies and Procedures (Regulations) which include:

- Classroom Guidelines
- Parent Handbook
- Discipline Policy
- Suspension and expulsion
- Emergency plans
- Procedures for conducting health checks
- Safe Sleep
- Procedures for parents to discuss concerns with the director
- Procedures for parents to participate in operation activities
- Procedures for release of children
- Illness and exclusion criteria
- Procedures for dispensing medications
- Immunization requirements for children
- Meals and food service practices (AM and PM Snacks served, lunch purchased or brought)
- Procedures to visit the center without securing approval
- Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website

Signature

Date

Please check the one most applicable:

Parent Employee/Caregiver Volunteer

Payroll Deduction Authorization

(Please initial each line, sign and date)

____ I hereby give Burleson ISD permission to deduct my child/children's tuition from my payroll for the 20____-20____ school year.

____ I understand that this will be deducted every month according to the Plan I have chosen.

____ I have chosen the following Plan:
____ Plan A: (September-August)
____ Plan B: (September-June)

____ I understand that my child/children's annualized tuition rate is based on their daily rate multiplied by the days the daycare is open, then divided by the months chosen in Plan A or B as stated above.

____ I understand that I can also pay the Registration fee, Supply fee, Activity fee through Payroll deduction. By checking the appropriate box below, I authorize my fees to be paid through payroll deduction, as well.

___ No, I will pay the fees through the on-line payment system.

___ Yes, please deduct my child's fees using the same payment schedule as the tuition.

____ I understand that lunch purchases are paid separately.

Signature

Date

Employee number _____

(Updated 8/2012)

Policy Addendum

Physical Activity Policy

Our physical activity policy aligns with Texas Minimum Standards for Licensed Child-Care Centers; As a requirement we will provide opportunities for children to play outside twice per day if weather permits. Please dress your child in attire according to climate. Activities in addition to playground equipment are available to reinforce learning.

Inclement Weather & Emergency Closings Policy

It is our intention that we provide care for all scheduled days of operation; however, situations beyond our control may occur that may disrupt service.

If we close after you have already dropped off your child, you or an emergency contact will be promptly notified so that you may make arrangements to pick up your child. We follow the Burleson ISD school closure schedule for inclement weather.

Attendance Policy

Absences

Prompt notification is required if your child will be absent. We ask that you explain the nature of the absence. If your child will be absent due to illness, please provide proper documentation from a pediatrician indicating the diagnosis as well as the date your child may return to school.

Withdrawing Your Child

If you decide to withdraw your child, we ask that you give a two-week notice.

Parent Signature: _____

Date: _____

Health Form

**Burleson ISD Child Care
421 Jayellen
Burleson, TX 76028
817-245-1250
817-245-1270 (fax)**

This form must be completed and signed by a physician.

Child's Name: _____ Parent's Name: _____
Child's DOB: _____ Address: _____

I have examined the above named child within the last 12 months and do _____ do not _____ believe this child is able to participate in the activities of a child care center.

Physician, please note any disabling conditions, physical or mental, affecting the child's ability to participate in group activities. Also, please include any special diet restrictions.

(Physicians signature) (Date)
Address: _____
Phone: _____

***This form must be returned to the child care facility within 1(one) week of start date.**



Parent/Physician Request for Administration of Medication

Written instructions from the doctor and parent and doctor signatures are required in order to give your child any form of medication at school. This includes over-the-counter medications and prescriptions.

- Prescribed medicine must be in the original bottle and have a current prescription label on the bottle.
- Over-the-counter medicine must be in the original container.
- Changes in medication will require a new up-dated form, signed by physician and/or parent/guardian
- Whenever possible please give medication at home. "Three times a day" could be before school, after school, and at bedtime.

***If your child requires medication for a severe allergy reaction, such as an Epi-pen, a Severe Allergy Action Plan must be completed and submitted along with the medication needed at school. This plan will need to be signed by both the physician and parent/guardian and will be required instead of this medication form.*

***If your child requires any medication for asthma such as an inhaler, nebulizer medications, or other asthma medications, an Asthma Action Plan must be submitted along with the medication needed at school. This plan will need to be signed by both the physician and parent/guardian and will be required instead of this medication form.*

.....
Parent and Doctor Permission

Permission is granted for designated school personnel to administer medication to my child, as listed and approved by the prescribing physician.

 Student's Name

 Date of Birth

 Parent or Legal Guardian

 Date

(____) _____
 Telephone Cell

(____) _____
 Home or Business

**My signature indicates that I am giving permission for BISSD staff to contact the physician for additional information, if needed.*

Medication	Dosage	Time of Administration	Reactions/Side Effects

Permission is granted for designated school personnel to administer the above medications in the dosage prescribed, at the time prescribed.

 Prescribing Physician Printed Name

 Date

 Prescribing Physician Signature

(____) _____
 Office phone number

- *All permissions and forms must be up-dated every year. A new school year means a new form will be necessary.*