



ADMISSION INFORMATION

(If your child is not enrolled in public school, you must complete pages 1 and 2.)

Operation Name Gimmie A Break			Director's Name Jacqueline D. Ingram		
Child's Name			Date of Birth		Child's Home Telephone No.
Child's Home Address		City	State	Zip	
Date of Admission		Date of Withdrawal		How did you hear about us?	
Primary Guardian's Name		Relationship		Secondary Guardian's Name Relationship	
List telephone numbers where parents/guardian may be reached while child will be in care:		Mother's Home No.	Mother's Cell No.	Father's Home No.	Father's Cell No.
Give the name and phone number of 3 people to call in case of an emergency if parents / guardian cannot be reached:					
Contact 1 Name	Phone No.	Contact 2 Name	Phone No.	Contact 3 Name	Phone No.
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.					
Pick-Up 1 Name	Phone Number	Pick-Up 2 Name	Phone Number	Pick-Up 3 Name	Phone Number

Email Address _____	Driver's License # His _____	Hers _____
Father's Employer _____	Father's Work Telephone _____	
Mother's Employer _____	Mother's Work Telephone _____	
<input type="checkbox"/> RECEIPT OF WRITTEN OPERATIONAL POLICIES: I acknowledge receipt of the facility's operational policies including those for discipline and guidance.		

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: Clear Lake Regional	Address: 500 Medical Center Blvd. Webster, TX.	Ph.#: 281-332-2511
I give consent for the facility to secure any and all necessary emergency medical care for my child. X		
_____ 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) 414-0301 (voice) or (800)-514-0383 (TTY).

SCHOOL AGE CHILDREN:	
My child attends the following school:	
_____	_____
Name of School and Address	School Ph.#
CHECK ALL THAT APPLY:	
<input type="checkbox"/> His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current.	
<input type="checkbox"/> Vision and Hearing screening records are also on file.	
Name of sibling(s):	

X

Signature – Parent or Legal Guardian

Date

ADMISSION INFORMATION

HEALTH REQUIREMENTS

Name of Child:	Date of Birth:
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Age ► Vaccine ▼	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	2-3 Yrs	4-6 Yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus influenzae type b											
Pneumococcal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											

TB TEST (if required)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date: _____
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Signature or stamp of a physician or public health personnel verifying immunization information above. **X** _____

Signature Date

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.

X _____

Parent's signature Date

I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

For additional information regarding immunizations contact the Department of State Health Services at http://www.dshs.state.tx.us/immunize/school_info.htm

ADMISSION REQUIREMENT: If your child does not attend public school, one of the following must be presented when your child is admitted to the child-care operation.
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 physically able to take part in the day care program.

X _____

Health Care Professional's Signature Date

2. A signed and dated copy of a health care professional's statement is attached.

Name and address of health care professional:
X _____

Signature - Parent or Legal Guardian	Date
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Gimmie A Break

Credit/Debit Card Payment

Authorization Form

Customer/Contract ID: _____ Mobile Phone: _____

First Name: _____ Daytime Phone: _____

Last Name: _____ Evening Phone: _____

Child's Name(s): _____

Email: _____

Address: _____

City: _____ State: _____ Zip code: _____

Card Type: AMEX Mastercard Visa Discover

Card Number: _____ Expiration Date (MMYY): _____

Name on Card: _____

Billing Address: _____

City: _____ State: _____ Zip code: _____

PAYMENT AUTHORIZATION

I authorize Gimmie A Break to charge the above credit card for ongoing child care services provided at the agreed upon rate. This authorization shall include tuition payments, hourly childcare services, meals, and activity fees. This authorization will remain in effect until I provide written direction to terminate this agreement for ongoing charges or until the tuition period expires.

I represent that I am authorized to execute this payment authorization.

Customer Signature: _____ Date: _____