DISD Rosella Scott Gator Academy Admission Information

General Information					
Operation's Name:		Director's Name:	Director's Name:		
DISD Rosella Scott Gator Academy		Janet Lopez	Janet Lopez		
Child's Full Name:		Child's Date of Birth:	Child Lives Both par		
Child's Home Address:		Date of Admission:		Date of Withdrawal:	
Name of Parent or Guardian Completing Form:		Address of Parent or G	Address of Parent or Guardian (if different from the child's):		
List phone numbers below where	parents or guardian may be re	eached while child is in care.			
Parent 1 Phone No.: Parent 2 Phone No.: Guardian's Phone No.:			Custody Documents on File? Yes No		
In case of an emergency, call:		<u> </u>	"		
Name of Emergency Contact:		Relationship:		Area Code and Phone No.:	
Address:					
				following persons. Please list name nated by the parent or guardian after	
Name:		Area Code and Phone No.:			
Name:		Area Code and Phone No.:			
Name:		Area Code and Phone No.:			
	Ca	onsent Information	L		
4 T	Co	insent information			
1. Transportation:					
I give consent for my child to be to	ransported and supervised by	the operation's employees (Check all tha	it apply).	
for emergency care	on field trips	m home	chool		
2. Field Trips:					
I give consent for my child to p	earticipate in field trips. OI do	o not give consent for my ch	ld to participa	ate in field trips.	
Comments:					

			rage 2 / 04-2025	
3. Water Activities:				
I give consent for	r my child to participa	ate in the following w	rater activities (Check all that apply).	
water table play	sprinkler play	splashing or wadir	ng pools	
Is your child able to	Is your child able to swim without assistance: Yes No If no, what type of assistance is needed:			
4. Receipt of Written	Operational Policies			
I acknowledge receipt	of the facility's operation	nal policies, including t	hose for (Check all that apply).	
Discipline and guid	dance		Procedures for release of children	
Suspension and ex	xpulsion		☐ Illness and exclusion criteria	
Emergency plans			Procedures for dispensing medications	
Procedures for cor	nducting health checks		☐ Immunization requirements for children	
Safe sleep			☐ Meals and food service practices	
Procedures for parents to discuss concerns with the director		ns with the director	Procedures to visit the center without securing prior approval	
Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions		activity including	Procedures for supporting inclusive services	
☐ Procedures for parents to participate in operation activities ☐ Procedures for parents to contact Child Care Licensing (CCL), DI Child Abuse Hotline, and CCL website		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 whi	le in care (Check all that apply):	
☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack				
6. Days and Times in	n Care:			
My child is normally in	n care on the following o	days and times:		
Day of the Week	A.M.	P.M.		
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Child's Special Care Needs (check all that apply)			
☐ Environmental allergies		Limitations or restrictions on	n child's activities
Food intolerances		Reasonable accommodation	ns or modifications
Existing illness		Adaptive equipment (include	e instructions below)
Previous serious illness		Symptoms or indications of complications	
☐ Injuries and hospitalizations (past 12 mod	nths)	☐ Medications prescribed for o	continuous long-term use
Other:			
Explain any needs selected above:			
Does your child have diagnosed food allergie	es? OYes ONo Foo	d Allergy Emergency Plan Subn	nitted Date:
Child day care operations are public accommwww.ada.gov/resources/child-care-centers/.may call the ADA Information Line at (800) 5	. If you believe that such an o	operation may be practicing disc	
Signature — Parent or Legal Guardian		Date Signed	
School Age Children			
My child attends the following school:			School Area Code and Phone No.:
My child has permission to (check all that ap,	pply):		
walk to or from school or home ride	e a bus be released to t	he care of his or her sibling und	er 18 years old
	d hearing screening, and TB	gency Medical Attention	
In the event I cannot be reached to arrange		, I authorize the person in charg	
Name of Physician Add	dress		Phone No.
Name of Emergency Care Facility Add	dress		Phone No.
I give consent for the facility to secure any and all necessary emergency medical care for my child. Signature — Parent or Legal Guardian Date Signed			

	Req	uirements for Exclusion from	Compliance	
	ached a signed and dated affidavit s ribed by Section 161.0041 Health a			
	ached a signed and dated affidavit s denomination that I am an adherent		eening conflicts with the tenets or	practices of a church or
		Vision Exam Results		
Right Eye 20/ Pass Fail				
Signature		Date Signe	od .	
		Hearing Exam Result	s	
Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				O Pass O Fail
Left				Pass Fail
Signature			<u></u>	
			···	
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. (Select only one option.)				
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.				
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 child care operation.				
Inorthis of authission, I will obtain a health care professional's signed statement and submit it to the child care operation.				
Name of Health Care Professional, if selected Address of Health Care Professional, if selected				
Signature — Health Care Professional Date Sig				
Signature —	Signature — Parent or Legal Guardian Date Signed			
Signature —	aroni or Logar 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 (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)			
	12–15 months (fourth dose)			
Inactivated Poliovirus	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.			

Varianta (6	Ohiologua ay		
varicella (C	Chickenpox)		
Varicella (chickenpox) vaccine is not required if your child has had chick	cenpox disease. If your child has had chickenpox, please complete the		
statement: My child had varicella disease (chickenpox) on or about [dat	e] and does not need varicella vaccine.		
	_		
Signature	Date Signed		
Additional Information F	Pogarding Immunizations		
Additional information r	Regarding Immunizations		
For additional information regarding immunizations, visit the Texas Dep	artment of State Health Services website at www.dshs.state.tx.us/		
immunize/public.shtm.			
TD T / //	Construction IV		
IB lest (I	If required)		
Positive Negative Date:			
	_		
Gang F	ree 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 S	Statement		
HHSC values your privacy. For more information, read our privacy policy	v online at: https://bbs.tavas.gov/policies-practices-privacy#security		
Thirise values your privacy. For more information, read our privacy policy	/ Offiline at: https://filins.texas.gov/policles-practices-privacy#security		
Signa	atures		
Child's Parent or Legal Guardian	Date Signed		
Center Designee	Date Signed		
Physician or Public Hea	Ith Personnel Verification		
•			
Signature or stamp of a physician or public health personnel verifying im	imunization information above:		
Signature	Date Signed		