ADMISSION INFORMATION

Operation Name			Director's Name	
Steiner Christian Preschool			Corinne Bonneau	
Child's Name	Name Child Goes By		Date of Birth	Child's Home Telephone No.
Child's Home Address	City	State	Zip	
Date of Admission Sept 3, 2024	Email Address		Hours and days child will be in care (9:00am-1:00pm): TWTH MTWTH	
Parent's or Guardian's Names			Address (if different from child's address)	
List telephone numbers where parents/guardian may be reached while child is in care.	Mother's Work:	Cell:	Father's Work:	Cell:	Guardian's Telephone No.

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

Name:	Phone:	Relationship:
Address:	City:	State/Zip

I hereby authorize Steiner Christian Preschool to allow my child to leave SCP ONLY with the following persons. Please list the 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.

Name:	Name:	Name:
Phone:	Phone:	Phone:

☐ 1. **OPERATIONAL POLICIES, DISCIPLINE & GUIDANCE POLICY AND PARENTAL RIGHTS:** I acknowledge that I have read online the facility's Operational Policies, Discipline and Guidance Policy and Parental Rights.

☐ YES ☐ NO INITIAL: _____

☐ 2. ***WATER ACTIVITIES*:** I hereby give my consent for my child to participate in water activities including sprinkler play and water table play.

☐ YES ☐ NO INITIAL: _____

☐ **3. *PHOTO CONSENT:*** My child may be photographed by Steiner Christian Preschool during regular business hours. These photographs may be used in art, crafts, social media and for children to take home as memorabilia. They may also be used for the purpose of promoting and marketing Steiner Christian Preschool website and print advertising, etc.

☐ YES ☐ NO. INITIAL: _____

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 Emergency Medical Care Facility (circle one or fill out OTHER):

☐ Family Emergency Hosp. at Lake Travis 5012 Ranch Rd. 620 N. Austin TX 78732 PH# 512-851-1011	☐ Baylor Scott & White Lakeway 100 Medical Pkwy Lakeway TX 78738 PH# 512-654-5000	☐ Dell Children's Medical Center 4900 Mueller Blvd. Lakeway TX 78732 PH# 512-324-0000
☐ St. David's North 12221 N. Mopac Exp. Austin TX 78758 PH# 512-901-1000	☐ OTHER:(Provide Name, Address & PH#)	

List any special diagnosed 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, and any other information which SCP should be aware of:

Allergies Y/N If Yes: Emergency Plan Submitted DATE:_____

Pleases list:

Name of your child's Pediatrician:	**Address:**	**Phone:**

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ADMISSION REQUIREMENT: ONE of the following **MUST** be presented when your child is admitted to the childcare program 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 childcare 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 childcare program. Within 12 months of admission, I will obtain a signed statement from the health care professional listed below.

Health Care Professional's Name:_____ Date Expected:_____

X_____ Date:_____
Parent Signature: