

# World Of Wisdom

## Hourly Child Care

For Office Use Only	CIN
Admission Date:	

We call it Learning, Kids call it Fun

### Child's Information

Child's Name:	Birthday	Gender: <input type="checkbox"/> boy <input type="checkbox"/> girl	Allergies / Medical Conditions or Concerns	
Address:				
Street	Apt/Suite	City	State	Zip

### Parent/Guardian Information

Parent/Guardian's Name:	Telephone:	Parent/Guardian's Name:	Telephone:
Driver's License	Email:	Driver's License	Email:
Employer:	Work Phone:	Employer:	Work Phone:
Address: <input type="checkbox"/> Same As Child's		Address: <input type="checkbox"/> Same As Child's	

### Emergency Contact (other than parents)

Emergency Contact Name:	Telephone:			
Address:				
Street	Apt/Suite	City	State	Zip

### Authorized Pick-up Person(s)

Name:	Name:	Name:
Telephone:	Telephone:	Telephone:

### Check All That Apply

I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

I give consent for my child to participate in water table activities such as bubble play.

I give consent for my child to be transported and supervised by the operation's employees for emergency care.

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

**\*\*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:**

Clear Lake Regional / 500 Medical Center Blvd. Webster TX 77598 / (281) 332-2511

Methodist St. John / 18300 St. John Dr. Nassau Bay, TX 77058 / (281) 333-5503

Other: / /

### Immunization

I HAVE SUBMITTED A COPY OF MY CHILD'S SHOT RECORD WITH THIS FORM  
(OR)

MY CHILD ATTENDS THE FOLLOWING **PUBLIC SCHOOL**.....

SCHOOL NAME	ADDRESS	SCHOOL TELEPHONE NUMBER
<input type="checkbox"/> HIS/HER IMMUNIZATION RECORD IS ON FILE AT THE SCHOOL AND ALL REQUIRED IMMUNIZATION AND/OR TUBERCULOSIS TEST ARE CURRENT. VISION AND HEARING SCREENING RECORDS ARE ALSO ON FILE.		

### Health Statement

I have submitted a health statement from my child's doctor with this form  
(OR)

My Child has been examined by a health care professional within the past year and is able to participate at World Of Wisdom. I will submit a signed statement from a health care professional within 12 months of the date of admission.

NAME	ADDRESS
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(OR)

My child attends a public school where this information is currently on file.

Signature - Parent/Legal Guardian:	Date:
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