
AUSTIN NATURE AND SCIENCE CENTER

NATURE'S WAY PRESCHOOL

MEDICAL INFORMATION AND RELEASE FORM

Participant name _____ Age _____ DOB _____

Program Name _____ Date of Camp Session _____

Mother/Guardian Name _____ home phone _____ work phone _____

Father/Guardian Name _____ home phone _____ work phone _____

Home Address _____

In case of emergency, contact _____ Phone _____

Address of emergency contact _____ zip code _____

Doctor's Name: _____ Doctor's Phone _____

The staff of the Austin Nature and Science Center takes every precaution to make each program as safe as possible. Please fill out the following information as additional protection for your child. *If you answer yes to any of these questions, please elaborate.*

1. Level of swimming ability:

- ☐ Beginner: float on stomach and put face in water
- ☐ Intermediate: swim 10 yards, float on back, swim underwater
- ☐ Advanced: swim 25 yards, swim freestyle and backstroke, jump and dive.

2. Does your child wear glasses or contacts?

3. Does your child have any physical condition that could restrict activities?

4. Does your child have any special needs of which we should be aware?

5. Is your child on any medication or under any doctor's orders?

6. Does your child have lice?

7. Does your child attend public school?

If no, does your child have all current immunizations?

8. Allergies:
- ☐ food _____
 - ☐ drugs _____
 - ☐ insect stings _____
 - ☐ Poison Ivy
 - ☐ hay fever
 - ☐ asthma

I do hereby give permission for my child to go on walking field trips on ANSC site during camp. I give permission for my child to participate in water activities such as splashing and wading on ANSC site.

I do hereby acknowledge that my child may be photographed by the City of Austin Parks and Recreation Department during programs sponsored by said agency and its facilities and do hereby consent to use of these photographs by said agency and its facilities for promotional purposes and displays.

**PLEASE COMPLETE INFORMATION ON OTHER SIDE OF THIS PAGE
PARENT MUST SIGN AND DATE AT BOTTOM OF OTHER SIDE**

AUSTIN NATURE AND SCIENCE CENTER

PERMISSION TO ADMINISTER MEDICATION

I authorize the Austin Nature and Science Center to give _____
CHILD'S NAME

the drug _____ in the quantity of _____
NAME OF THE DRUG OR PRESCRIPTION AMOUNT

at this time of day _____ on the following days that s/he will be at
TIME OR TIMES OF DAY

the Austin Nature and Science Center: _____
DATES TO BE GIVEN THE MEDICATION

Parent's or Physician's Signature: _____ Date: _____

Name or Medication Number	Time Given	Given by	Date

PICK-UP AUTHORIZATION

My child may leave ANSC site only with the persons listed below.

My child, _____, has permission to be picked up
CHILD'S NAME

by _____ after camp at _____ p.m. on _____.
NAME OF ADULT TIME DATE

Parent/Guardian Signature: _____ Date: _____

In consideration of participant being allowed to participate in the registered class(es) or program(s), the undersigned hereby releases the City, its employees and agents, from any action, claim, or demand for personal injury or property loss arising from or due to any negligent act or omission of the City, its agents or employees. This release shall have no effect with regard to damages caused by the City's gross negligence. In the event the City or a volunteer provides transportation for my child, this waiver and release shall extend to and release the volunteer driver or City employee driver from any and all liability aforesaid. Permission is given for any emergency medical treatment, operation, or anesthesia that might become necessary. I agree to be responsible for the expense of medical treatment or service.

PARENT/GUARDIAN: _____ Date: _____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE
AUTORIZACION PARA ATENCION MEDICA DE EMERGENCIA

**If I cannot be reached to make arrangements for
emergency medical care for my child at the time of an
illness or accident, I give my permission for:**

Si en caso de alguna enfermedad o accidente no me
pueden localizar para arreglar atención médica de
emergencia para mi niño, doy permiso para que:

Name of Day Care Facility Owner or Director
Nombre del Dueño o Director del Centro de Cuidado de Niños

to take my child (or children):

a que lleve a mi niño (o mis niños):

Name of Child (1)/Nombre del Niño (1)

Name of Child (2)/Nombre del Niño (2)

Name of Child (3)/Nombre del Niño (3)

Name of Child (4)/Nombre del Niño (4)

to:

a:

Name of Doctor/Nombre del Doctor

Telephone No./Teléfono

Address of Doctor/Dirección del Doctor

or to:

o a:

Name of Hospital or Clinic/Nombre del Hospital o Clínica

Telephone No./Teléfono

Address of Hospital or Clinic/Dirección del Hospital o Clínica

**I give consent for necessary emergency treatment
when my child is in the care of this physician or
hospital or clinic.**

Doy mi consentimiento para el tratamiento médico
necesario estando mi niño bajo la atención de este
doctor u hospital o clínica.

Signature-Parent or Legal Guardian
Firma-Padre o Tutor

Date/Fecha

Discipline and Guidance Policy for _____

Name of Operation

- ◆ Discipline must be:
 - (1) Individualized and consistent for each child;
 - (2) Appropriate to the child's level of understanding; and
 - (3) Directed toward teaching the child acceptable behavior and self-control.

- ◆ A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:
 - (1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
 - (2) Reminding a child of behavior expectations daily by using clear, positive statements;
 - (3) Redirecting behavior using positive statements; and
 - (4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.

- ◆ There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:
 - (1) Corporal punishment or threats of corporal punishment;
 - (2) Punishment associated with food, naps, or toilet training;
 - (3) Pinching, shaking, or biting a child;
 - (4) Hitting a child with a hand or instrument;
 - (5) Putting anything in or on a child's mouth;
 - (6) Humiliating, ridiculing, rejecting, or yelling at a child;
 - (7) Subjecting a child to harsh, abusive, or profane language;
 - (8) Placing a child in a locked or dark room, bathroom, or closet with the door closed;and
 - (9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Texas Administrative Code, Title 40, Chapters 746 and 747, Subchapters L, Discipline and Guidance

My signature verifies I have read and received a copy of this discipline and guidance policy.

Signature

Date

Check one please:

☐ parent

☐ employee/caregiver

☐ household member of child-care home

Nature's Way Preschool

Nature's Way Preschool
Austin Nature and Science Center

301 Nature Center Dr. Austin, Texas 78746
Trailhouse (512) 329-8238

ANSC (512) 974-3888
fax (512) 974-3885

Car Seat Rules/ Waiver

“As of September 1, 2009; Texas SB 61 requires that any child younger than 8 years of age be restrained in an approved child passenger safety seat unless the child is taller than 4 feet 9 inches in height.”

***If your child is required to use a car seat by law,
you must follow these guidelines for
NWPS field trips.***

- 1. Parents will be responsible for placing the car seat in the van at morning drop off. Please see your teacher for any seating charts, etc)**
- 2. Parent will check the seat to make sure it is secure.**
- 3. Parent will inform teachers of any specifics involved in securing child in the car seat.**
- 4. If parent is present before departure, parent is encouraged to put child in car seat and secure child in car seat.**
- 5. If you have any questions, please feel free to call the preschool director at 512-974-3882.**

My child, _____ will be traveling via a City Vehicle between the days of September 19, 2011 and May 4, 2012.

I have read and understand the above guidelines for using a car seat in a City of Austin Vehicle.

PARENT/GUARDIAN: _____ Date: _____

ADMISSION INFORMATION

Operation Name		Director's Name	
Child's Full Name		Child's Date of Birth	Child's Home Telephone No.
Child's Home Address			
Date of Admission	Date of Withdrawal		
Parent's or Guardian's Name		Address (if different from child's address)	
List telephone numbers below where parents/guardian may be reached while child will be in care:			
Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.	Cell Phone No
Give the name, address and phone number of person to call in case of an emergency if parents / guardian cannot be reached:			Relationship
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.			

CHECK ALL THAT APPLY:			
I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give – consent for my child to be transported and supervised by the operation's employees:			
1. <input type="checkbox"/> TRANSPORTATION:			
Walk home <input type="checkbox"/> for emergency care <input type="checkbox"/> on field trips <input type="checkbox"/> to and from home <input type="checkbox"/> to and from school			
2. <input type="checkbox"/> FIELD TRIPS: I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give – my consent for my child to participate in Field Trips:			
Parent's Comments:			
3. <input type="checkbox"/> WATER ACTIVITIES: I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give – my consent for my child to participate in Water Activities:			
<input type="checkbox"/> sprinkler play <input type="checkbox"/> splashing/wading pools <input type="checkbox"/> swimming pools <input type="checkbox"/> water table play			
4. <input type="checkbox"/> RECEIPT OF WRITTEN OPERATIONAL POLICIES:			
I acknowledge receipt of the facility's operational policies including those for discipline and guidance.			
5. I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:			
<input type="checkbox"/> None <input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack			
6. MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:			
<input type="checkbox"/> Mondays	from:	to:	
<input type="checkbox"/> Tuesdays	from:	to:	
<input type="checkbox"/> Wednesdays	from:	to:	
<input type="checkbox"/> Thursdays	from:	to:	
<input type="checkbox"/> Fridays	from:	to:	
<input type="checkbox"/> Saturdays	from:	to:	
<input type="checkbox"/> Sundays	from:	to:	

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:	Address:	Ph.#:
I give consent for the facility to secure any and all necessary emergency medical care for my child.		
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) 514-0301 (voice) or (800)-514-0383 (TTY).

Signature – Parent or Legal Guardian

Date

SCHOOL AGE CHILDREN:

☐ My child attends the following school:

Name of School and Address

School Ph.#

CHECK ALL THAT APPLY:

☐ His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

My child has permission to: ☐ walk to or from school or home,
☐ ride a bus, and/or ☐ be released to the care of his/her sibling(s) under 18 years old.

Name of sibling(s): _____

IMMUNIZATION RECORD:

☐ I have provided the childcare operation with a copy of my child's most current immunization record.

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.

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 day care 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 day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

Name and address of health care professional: _____

Signature - Parent or Legal Guardian

Date

VISION	R 20/ _____	L 20/ _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE _____		DATE _____	
HEARING	1000 Hz	2000 Hz	4000 Hz
R	_____	_____	_____
L	_____	_____	_____
SIGNATURE _____			<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
DATE _____			

Signature – Parent or Legal Guardian

Date

ADMISSION INFORMATION

HEALTH REQUIREMENTS

Name of Child:

Date of Birth:

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)

☐ Positive

☐ Negative

Date:

Signature or stamp of a physician or public health
personnel verifying immunization information above.

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.

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

www.dshs.state.tx.us/immunize/public.shtm

Signature – Parent or Legal Guardian

Date