325 Barbara Mae St, Houston, TX 77015
Phone 832-386-3760 Fax 832-386-2013 Phone 832-386-2090 Fax 832-386-2091

Student Parent Enrollment Checklist

Child's Name:	
District Student's Name:	
	Copy of Birth Certificate or Birth Facts with hospital stamp
	Current copy of child's Immunization record must be signed or stamped by the doctor's office
	P.E.P. Student Application Form
	Nutritional Intake Form
	Emergency Contact Form
	Getting to Know Your Child Form
	Consent for Release of Confidential Information
	Parental Permission to take Pictures Form
	Clothing Permission Form
	Parent's Enrollment Agreement and Acknowledgement Page
	UWBB–Participation for Program Evaluation
	GPISD Student Nutrition –

April 2023

Use this form to collect all required information about a child enrolling in day care.

: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

Operation's Name: Galena Park ISD Childcare Center	Director's Name:	
Child's Full Name:	Child's Date of Birth:	Child Lives With? ◯ Both parents ◯ Mom ◯ Dad ◯ Guardian
Child's Home Address:	Date of Admission:	Date of Withdrawal:

Name of Parent

			◯ Yes ◯ No
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:

Address:

	Area Code and Phone No.:
Name:	Area Code and Phone No.:

☐ ☐ ☐ ☐

◯ I give consent for my child to participate in field trips. ◯ I do not give consent for my child to participate in field trips.

Comments:

I give consent for my child to [illegible]

☐ ☐ ☐ ☐ ☐

_____

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[redacted]

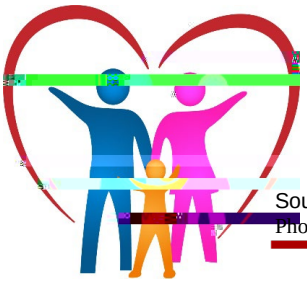
The following vaccines require multiple doses over time. Please provide the date your child received each dose.

[redacted]

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the

_____

_____



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Phone 832·386·3760 ◊ Fax 832·386·2013 Phone 832386-2090◊ Fax 832386-2091

EMERGENCY CONTACT, CONSENT, AUTHORIZATION & RELEASE FORM

Childs Name: _____ Date of Birth: _____/_____/_____

Address: _____ Phone:_____

_____

Parent's Name: _____ Email: _____
First MI Last

Address:_____ Phone:_____

_____

Parent's Name: _____ Email: _____
First MI Last

Address:_____ Phone:_____

_____

Contact Name:_____
First MI Last

Relationship to child: _____

Address: _____
Number Street Apt. #

_____
City

_____

Contact Name: _____
First MI Last

Relationship to child: _____

Address: _____
Number Street Apt. #

_____
City State Zip Code

Phone: Work: ( ) _____ Cell ( ) _____ Home: ( ) _____

Contact Name: _____
First MI Last

Relationship to child: _____

Address: _____
Number Street Apt. #

_____
City State Zip Code

Phone: Work: ( ) _____ Cell ( ) _____ Home: ( ) _____

Contact Name: _____
First MI Last

Relationship to child: _____

Address: _____
Number Street Apt. #

_____
City State Zip Code

Phone: Work: ( ) _____ Cell ( ) _____ Home: ( ) _____

South Campus

South Campus 1906 2nd St. Galena Park, TX 77547
Phone 832·386·3760 Fax 832·386·2013

North Campus 825 Barbara Mae St. Houston, TX 77015
Phone 832-386-2090 Fax 832-386-2091

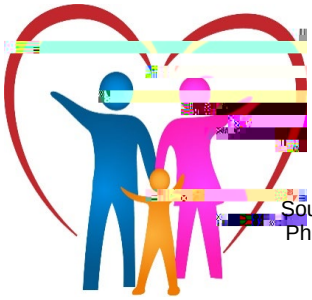
GALENA PARK I.S.D. CHILDCARE CENTER

South Campus 1906 2nd St. Galena Park, TX 77547 North Campus

South Campus 1906 2nd St. Galena Park, TX 77547
Phone 832·386·3760 Fax 832·386·2013

North Campus 825 Barbara Mae Houston, TX 77015
Phone 832-386-2090 Fax 832-386-2091

Behavior:



GALENA PARK I.S.D.
CHILDCARE CENTER

South Campus · 1906 2nd St. Galena Park, TX 77547
Phone 832·386·3760 · Fax 832·386·2013

North Campus · 325 Barbara Mae St., Houston, TX 77015
Phone 832-386-2090 · Fax 832-386-2091

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of child_____ Date of Birth _____/_____/_____

Parent/Guardian Name: _____ Ph.#: _____

Please authorize the person or agency name below to release specific records containing con. _____

_____

Phone Number _____ Fax Number _____

The following information is requested to be released (mark all that apply):

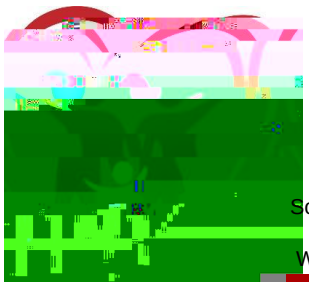
- Authorization to attend Child Care
- Immunization Records
- Operative Reports
- Progress Notes
- Discharge Summary
- Recommendations for follow care
- Physical(s) Well Child Exam(s) for ___ month(s)
- Dental Exam
- Other (please list): _____

Please fax or send copies to:
Attention: Nurse

- 1906 2nd St., Galena Park, TX 77547 Office: 832-386-3760 Fax: 832 386-2013
- 325 Barbara Mae St., Houston, TX 77015 Office: 832-386-2090 Fax: 832 386-2091

I authorize the above agency/person to disclose and provide copies of the information marked above.

I understand the information disclosed by this authorization may be subject to disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. Employees of this agency are hereby released from any



South Campus 1906 2nd St. Galena Park, TX 77547 North Campus 825 Barbara Mae St., Houston, TX 77015

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Parental Notification of Lack of Liability Insurance

Directions: An operation may use this form to notify each child's parent that the operation does not provide liability insurance. The operation must keep on file any notification to the parent.

Operation's Responsibility to Notify Parents of the Lack of Insurance

Unless the operation has an acceptable reason not to provide the insurance, the Human Resources Code §§42.049 or 42.0495 requires a licensed, registered or listed child care operation to have liability insurance:

- x in the amount of $300,000 for each occurrence of negligence; and
- x that covers injury to a child that occurs while the child is in care, regardless of whether the injury occurs on or off the premises of the operation.

An operation does not have to carry the insurance or may discontinue coverage if the operation is unable to obtain coverage because of financial reasons, cannot find an underwriter willing to issue a policy or has exhausted the limits of the policy. However, the operation must notify in writing the parent of each child in care if the operation does not provide the liability insurance.

Parent/Guardian Acknowledgement of the Operation's Lack of Insurance

As the parent/guardian of the child(ren) listed below, I acknowledge that the operation caring for my child(ren) does not have liability insurance coverage.

_____ _____
Signature of Parent/Guardian Date Signed/Notified

_____
Printed Name of Parent/Guardian

_____
Name(s) of Parent/Guardian's Child(ren) in the Operation's Care

_____
Name of Operation

, Houston, TX 77015
Phone 832·386·3760 Fax 832·386·2013 Phone 832-386-2090 Fax 832-386-2091

PARENTAL PERMISSION TO TAKE PICTURES

Dear Parent/ Guardian:

The Galena Park I.S.D. Childcare Center would like permission to take pictures of your child/children to be used in the classroom and/or to add them to our program presentations which are presented to the Galena Park I.S.D. Board of Trustees and any other organization requesting a presentation from the center.

Please check one or more boxes below if you consent for the Galena Park I.S.D. Childcare Center to take pictures of your child.

I give my parental permission for my child, _____ to have his/her picture taken by Galena Park I.S.D. Childcare Center staff for use in the center and classroom, including Class Dojo® or Brightwheel®.

I give my parental permission for my child, _____ to have his/her picture taken by Galena Park I.S.D. Childcare Center staff for use in presentations given to the Galena Park I.S.D. Board of Trustees and any other organization requesting presentations from the center for educational purposes only.

I DO NOT give parental permission for my child to have his/her picture taken at the Galena Park I.S.D. Childcare Center for any reason.

Signature of Parent/Guardian: _____ Date: ___/___/____

, Houston, TX 77015
Phone 832·386·3760 Fax 832·386·2013 Phone 832-386-2090 Fax 832-386-2091

Student Parent's Enrollment Agreement and Acknowledgements

I have received Operational Discipline and Guidance Policy (included with parent handbook), and its contents were discussed with me.

I have received the Galena Park I.S.D. Childcare Center's Breastfeeding Policy (included with parent handbook), and its contents were discussed with me.

It is my responsibility to understand and familiarize myself with the parent handbook and to ask center management any questions I may have regarding any policy, procedure or information contained in the Galena Park I.S.D. Childcare Center Parent Handbook (hard copy handbook located online on the GPISD Website).

I have received information on Gang Free Zones (included with the parent handbook) and its contents were discussed with me.

I understand the Childcare Center's hours of operation for student parents are 6:30 am. to 3:00 p.m. Monday through Friday except for scheduled school closings, staff development, and school holidays as noted on the school calendar.

I understand that childcare services are provided only during the time I attend school. If I leave school, I must notify the center immediately that I'm on my way to pick up my child. Alternate childcare arrangements with the director must be made for your child if you are unable to pick up your child at 3 pm.

I understand the center MUST be notified when my child will not be in attendance. After 5 or more consecutive absences without notification I must re-enroll.

I understand that if Ichoose to provide my child's meals and/or snacks from home, that the childcare center is not responsible for its nutritional value or for meeting the child's daily food needs. Food from home will be stored at the center in each child's assigned cubbies. Please do not bring items that require refrigeration or heating.

I understand that Galena Park ISD Childcare Center is a nut free campus. I agree that I will not send any food items with nuts as an ingredient.

ATTENTION PARENTS!

The following pages only need to be completed if your child has food allergies and needs adjustments made to the regular menu. If so, please select the infant form (for under 12 months old) or the regular form. Otherwise, you may disregard the remaining pages.

Physician's Request for Special Accommodations for Formula & Infant Food
Galena Park ISD Student Nutrition

All Sections must be completely filled out for this form to be accepted. *Indicates required field.

DATE: _____ SCHOOL YEAR: _____

A. THIS SECTION TO BE COMPLETED BY PARENT / LEGAL G_____

*Does the child have a disability and/or anaphylactic/life-threatening food allergy? ´ YES ´ NO

If YES selected, form must be completed and signed by licensed physician.

*If YES, please describe the major life activities affected by the disability: _____

*

*Qualifying Conditions/Diagnosis – Please Check all that Apply

- cardiovascular condition
- malabsorption sysdrome
- developmental delays (sensory and motor
- GI impairment
- low maternal weight gain/loss
- inadequate growth
- n_____
- food allergies (cow's milk, soy or intact proteins) FPIES
- GER/GERD
- prematurity/LBW
- FTT

_

_____

Formula Options

- ☐ Similac Sensitive (lactose sensitivity or colic)
- ☐ Similac for Spit-Up (excess spit-up or reflux)
- ☐ Similac Total Comfort (digestive issues or colic)

Infant Supplement Foods: Optional

Infant 6 to 11 months of age:
Check Foods to remove from menu

C. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY

I certify that the above named student needs special dietary accommodations, as described above, because of the student's disab
or life-threatening food allergy or food intolerance/allergy, as indicated.

z z z zMDz z´DDz z´NPz ˝PA

*Signature of Licensed Physician/Prescribing Medical Authority Date

*Printed Name of Licensed Physician/Prescribing Medical Authority

Phone Fax

Address

Send completed form to school nurse. Please submit new Physician Request form each school year. Any change or discontinuation must be submitted in writing b
the physician. Please allow two business weeks for processing. Scan completed forms to ALGRANT@galenaunified.org or call 832-886-1549 with questions or return
to the school nurse for further processing.

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DATE:______________________ SCHOOL YEAR:____________________

A. THIS SECTION TO BE COMPLETED BY PARENT / LEGAL GUARDIAN

*Student Last Name:________________________ *First Name:________________________ Date of Birth: ___/___/___

School:____ Grade:_________ Student ID: _________________

Parent/Guardian Name: ____ Phone: _____________________________

School Nurse: ____ Phone: ____________________

I give Health Services/Nutrition Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.

Parent Signature: ____ Date: __________________

B. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY

*Does the child have a disability and/or anaphylactic/life-threatening food allergy? ´ YES ´ NO If YES selected, form must be completed and signed by licensed physician.

*If YES, please describe the major life activities affected by the disability:________________________________

* ____

ACCOMMODATIONS NEEDED Lactose Free milk or Soy Milk is the standard substitution when Fluid Diary Milk please prescribe under Substitutions ^

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III. Supplement W NONE

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´ KšZ Œ W____ *Supplements may take up to 6 weeks to be processed.

}• P W Œ (REQUIRED) zzzz Œ l(•š ____Lunch zzzz (š Œ ûpper }o ^

IV. Therapeutic Diet Order W o • ‰Œ}À] •‰]] ÌÙ Galena Park ISD Student Nutrition

C. THIS SECTION TO BE COMPLETED BY LICENSED

Fecha: _____

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A. ESTA SECCIÓN DEBE LLENARLA EL PADRE O TUTOR

*Nombre del estudiante:_____ Fecha de Nac.: __/___/___

Escuela:_____ Grado:_____ ID: _____ Padre o tutor: _____ Teléfono: _____

Enfermera de la escuela: _____ Teléfono:_____

Doy mi autorización para que los Servicios de Salud o los Servicios de Nutrición hablen con el doctor o la autoridad médica que se menciona más adelante para disc necesidades de alimentación que se describen a continuación:

Firma del padre o tutor:_____ Fecha:

C.ESTA SECCIÓN DEBE LLENARLA UN MÉDICO LICENCIADO O LA AUTORIDAD MÉDICA PERTINENTE

Yo certifico que el estudiante que se menciona arriba necesita las modificaciones dietéticas descritas, dado que presenta discapacidad o una alergia alimentaria severa provocada por alimentos que ponen en riesgo su vida, como ya se ha menciona

z z z z z z z z z z z z z z z z z z z z z z z z z z z z z MD ÍDO Í NP Í PA z z z z z

*Firma del doctor o autoridad médica — Fecha

*Nombre del doctor o autoridad médica

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Entregue el forma lleno a la enfermera de la escuela. Deberá presentar uno nuevo cada año. Todo cambio o terminación de tratamiento debe comunicarse por escrito, de parte del médico. El trámite toma dos semanas. Mande la forma por scan a ALGRANT@galenaparkisd.com con preguntas contacte 832-386-1549 or return to school nurse for further processing.