



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

District Parent Enrollment Checklist

Child's Name: _____

Parent'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

Emergency Contact Form

Nutritional Intake Form

Getting to Know Your Child Form

Consent for Release of Confidential Information

Parental Permission Picture Form

Clothing Permission Form

District Payroll Deduction Form

Texas Dept. of Health & Human Services Admission Information (Pgs. 1-3, & 6)

Parental Notification of Lack of Liability Insurance

Parent's Enrollment Agreement and Acknowledgment Page

Forms To Be Completed by Child's Doctor:

Texas Dept. of Health & Human Services Admission Information (Pgs. 4-5)

Must include the following:

- Physician's Statement
- Vision & Hearing Exam
- Vaccinations/Immunizations (Shot record can be submitted separately)

Physician's Instructions for Diaper Cream **if needed**

GPISD Student Nutrition–Medical Statement **if needed** (Special Diets)



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EMERGENCY CONTACT, CONSENT, AUTHORIZATION & RELEASE FORM

Child's 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 _____ 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: _____

Galena Park ISD Childcare Center

2024-2025



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Nutritional Intake Form Ages 0 – 12 months

Name _____ Date of Birth _____

Type of Formula: _____ Amount (ounces) _____

How often? Every _____ hours Warmer? Yes No

Type of Diet: Cereal: _____ Meats: _____

Vegetables: _____ Fruits: _____

Allergies: Food: _____

Skin: _____

Other: _____

Symptoms Produced: _____

Skin Care: Ointment: _____ Special Soap: _____

(A note signed by a physician is required for center staff to apply any ointment or cream.)

Sleeping Position: On Back On Stomach On Side (A sleep exception form signed by a physician is required for any infant not placed on their back to sleep.)

Does your baby use a Pacifier? Yes No

Other Helpful Information: (Please include schedule for feeding, sleeping, etc.)

Parent's Signature _____ Date _____

Parent's Signature _____ Date _____

Parent's Signature _____ Date _____

Parent's Signature _____ Date _____

Parent's Signature _____ Date _____

Parent's Signature _____ Date _____

***NOTE: Please update this form as changes are made. Parents please re-sign and re-update this form every 30 days from date of last signature. ***



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NUTRITIONAL INTAKE FORM

Ages 1 to 5 years

Child's Name: _____

Child's Date of Birth: _____

Teacher: _____

Formula currently used for your child (if applicable): _____

How many ounces of milk does your child drink at a given time? _____

Other beverages (must have a doctor's note): _____

Please describe what your child typically eats in a day.

Time: _____

Time: _____

Time: _____

Time: _____

My child:

Likes: _____

Dislikes: _____

Is allergic to: _____

Takes vitamins/ supplements: _____

Additional Information: _____

Signature of Parent/Guardian: _____ Date: _____



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Getting to Know Your Child

Child Name: _____ Date of Birth: _____

Is there another name your child likes to be called by? _____

Mother's Name: _____ Father's Name: _____

Eating Preferences:

What are your child's favorite foods? _____

Dietary Preferences (vegetarian, dairy-free, etc.) _____

Food Allergies: _____

Does your child use utensils, eat with his/her hands, or feed himself/herself? _____

Does your child often choke when eating? _____

Have you started using a sippy cup or regular cup with your child? _____

Does your child take a bottle at any time? _____ If so, when? _____

Diapering/Toileting:

Does your child have sensitive skin? _____

Is your child prone to diaper rash? _____

How do you normally treat diaper rash? _____

Does your child need assistance with toileting? _____

If so, how can we best help? _____

Sleeping:

What time does your child go to bed at night? _____

What time does your child wake up in the morning? _____

Do you lay your child down and pat to sleep? _____

Does your child sleep in his/her own bed? _____



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Is he/she a light sleeper? _____

Are there any routines that are particularly helpful at naptime? _____

Behavior:

Does your child have any special fears? _____

How does your child communicate his/her needs? _____

Are there any special words your child uses that might not be readily recognized? _____

When your child gets upset, what helps him/her calm down? _____

Family History:

Tell us about your family (child's parents, sibling, grandparents, other extended family). _____

What are your concerns and goals for your child while he/she is here at the center? _____

What is your child's primary language? _____

What other languages is he/she exposed to? _____

Is there anything else you want to share that would help us provide continuity of care? _____

Activities:

What activities do you like to do with your child? _____

What activities does your child like to do when playing with other children? _____

What activities does your child like to do when playing alone? _____



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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 confidential information regarding the above-named child/student to ensure that the state licensing guidelines are met.

Name of agency/person to whom request is made:

Address of agency/person:

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 re-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 legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. This authorization is valid for one calendar year from the date of signature or earlier if I choose. I understand that I may revoke this authorization in writing except to the extent that disclosure of information has been made prior to receipt of the revocation.

Signature of Parent/Guardian: _____

Date: _____



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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 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: _____



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Clothing Permission Form

As you may know, learning, eating, and using the restroom can be messy for young children. Please send two complete changes of clothing for your child, so we can be prepared for a messy situation at school. Put these items in a Ziploc[®] bag labeled with your child's name on the bag so it does not get lost and it's easier to find it. We will keep his/her clothes at the center in case they are needed. Thank you!



- 2 – Shirts
- 2 – pairs of pants/shorts /dresses/skirts
- 2- pairs of socks
- 2- pairs of underwear (if applicable)

How would you like the center to address a need for emergency clothes in the event your child does not have extra at the center? **Please select one option below:**

You have my permission **without** a prior authorization call to provide clean, gently used clothes from the center, and I will return them the next school day.

You have my permission **with** a prior authorization call to provide clean, gently used clothes from the center, and I will return them the next school day.

You do not have my permission to use other clothes for my child. I will provide 2 extra sets of clothes for my child at all times. If my child does not have a change of clothes; I can be at the center within 15 minutes with a change of clothes or to pick them up.

I understand, as a parent, it is my responsibility to ensure my child has all items needed at the center for their toileting and dressing needs and to check in with staff to see if additional items are needed.

Child's name (please print)

Parent's Name (please print)

Parent's signature

Date



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CHILDCARE PAYROLL DEDUCTION AUTHORIZATION FORM

NAME (Please Print): _____
Last First MI

EMPLOYEE ID #: _____ CAMPUS/DEPARTMENT: _____

HOME ADDRESS: _____
STREET CITY ZIP

NAMES OF CHILDREN ENROLLED IN GALENA PARK I.S.D. CHILDCARE CENTER:

Last Name of Child	First Name of Child	Date of Birth	Age as of 9/1

Childcare costs are based upon a 187-day contract calendar.

A non-refundable registration fee of \$100.00 is due to secure your child's spot (non-refundable registration fee of \$50.00 is due for each additional sibling). Payment can be paid via RevTrak. A family handbook will be provided which explains all other rules and regulations regarding your child's enrollment at the Galena Park I.S.D. Childcare Center.

There will be no credit on tuition for any reason, e.g. bad weather, vacation, illness, maternity leave, or family medical leave. **If a child is to withdraw from the program, a two-week written notice must be provided to the Director of Childcare Services.**

The Childcare Center's hours of operation for district employees are: 6:30 a.m. to 5:15 p.m. on regular days, 6:30 a.m. to 4:00 p.m. on Early Dismissal days, and 7:00 a.m. to 4:30 p.m. on Staff Development days. A late fee of \$1.00 per minute will be charged if a child is picked up after closing time. The late fee will be paid by the next business day via RevTrak. The Childcare Center reserves the right to terminate the enrollment of a child who is picked up late four (4) times within a school year.

Employee's Signature _____ Date _____



Admission Information

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

Directions: 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.

General Information				
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 or Guardian Completing Form:		Address of Parent or Guardian (<i>if different from the child's</i>):		
List phone numbers below where parents or guardian may be reached while child is in care.				
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? <input type="radio"/> Yes <input type="radio"/> No	
In case of an emergency, call:				
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:	
Address:				
I authorize the child care operation to release my child to leave the child care operation ONLY with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.				
Name:			Area Code and Phone No.:	
Name:			Area Code and Phone No.:	
Name:			Area Code and Phone No.:	

Consent Information	
1. Transportation:	
I give consent for my child to be transported and supervised by the operation's employees (Check all that apply).	
<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	
<input type="radio"/> I give consent for my child to participate in field trips. <input type="radio"/> I do not give consent for my child to participate in field trips.	
Comments:	

3. Water Activities:

I give consent for my child to participate in the following water activities (Check all that apply).

☐ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds

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 operational policies, including those for: (Check all that apply. All topics are explained in Family Handbook.)

- | | |
|--|---|
| <input type="checkbox"/> Discipline and guidance | <input type="checkbox"/> Procedures for release of children |
| <input type="checkbox"/> Suspension and expulsion | <input type="checkbox"/> Illness and exclusion criteria |
| <input type="checkbox"/> Emergency plans | <input type="checkbox"/> Procedures for dispensing medications |
| <input type="checkbox"/> Procedures for conducting health checks | <input type="checkbox"/> Immunization requirements for children |
| <input type="checkbox"/> Safe sleep | <input type="checkbox"/> Meals and food service practices |
| <input type="checkbox"/> Procedures for parents to discuss concerns with the director | <input type="checkbox"/> Procedures to visit the center without securing prior approval |
| <input type="checkbox"/> Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions | <input type="checkbox"/> Procedures for supporting inclusive services |
| <input type="checkbox"/> Procedures for parents to participate in operation activities | <input type="checkbox"/> 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 while in care (Check all that apply):

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. Days and Times in Care:

My child is normally in care on the following 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)

Limitations or restrictions on child's activities

Reasonable accommodations or modifications

Adaptive equipment (*include instructions below*)

Symptoms or indications of complications

Medications prescribed for continuous long-term use

Other: _____

Explain any needs selected above:

Does your child have diagnosed food allergies?	Yes	No	Food Allergy Emergency Plan Submitted Date:
--	-----	----	---

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit <https://www.ada.gov/resources/child-care-centers/>. 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 Signed
---	--------------------

Date Signed

Home Language/Ethnicity

What is the primary language spoken in the child's home?

Other languages used in the home:

White

Black or African American

American Indian or Alaska Native

Asian

Native Hawaiian or Other Pacific Islander

Other

Please select one:

Hispanic or Latino

Not Hispanic or Latino

School Age Children	
1. Name of the child	
2. Date of birth	
3. Sex	
4. Address	
5. School	
6. Teacher	
7. Parent/Guardian	
8. Health status	
9. Immunization status	
10. Other notes	

My child attends the following school:

N/A

School Area Code and Phone No.:

	N/A
--	-----

My child has permission to (check all that apply):

N/A walk to or from school or home ride a bus be released to the care of his or her sibling under 18 years old

Authorized pick up or drop off locations other than the child's address:

N/A

N/A - Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization for Emergency Medical Attention

In the event I cannot be reached to arrange for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician

Address

Phone No.

Name of Emergency Care Facility

Address

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** _____

Date Signed _____

Varicella (Chickenpox)

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.

Signature

Date Signed

**Only complete this box if your child
has had chickenpox.**

Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm.

TB Test (If required)

☐ Positive ☐ Negative Date: N/A - not required

Gang Free 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 Statement

HHSC values your privacy. For more information, read our privacy policy online at: <https://hhs.texas.gov/policies-practices-privacy#security>

Signatures

Signature - Child's Parent or Legal Guardian

Date Signed

Signature - Center Designee

Date Signed



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:

- in the amount of \$300,000 for each occurrence of negligence; and
- 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

Galena Park ISD Childcare Center

Name of Operation



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District Parent's Enrollment Agreement and Acknowledgements

- ☐ I have received *Operational Discipline and Guidance Policy* (included with family handbook), and its contents were discussed with me.
- ☐ I have received the Galena Park I.S.D. Childcare Center's *Breastfeeding Policy* (included with family handbook), and its contents were discussed with me.
- ☐ I have received the *Galena Park I.S.D. Childcare Center Family Handbook*, and have reviewed it with a member of the Galena Park I.S.D. Childcare Center staff. The handbook may be updated from time to time, and notice will be provided as updates are completed. It is my responsibility to understand and familiarize myself with the family 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 Family Handbook*. (Handbook located online on the GPISD Website)
- ☐ I have received information on Gang Free Zones (included with the family handbook) and its contents were discussed with me.
- ☐ I understand that there will be no credit on tuition for any reason, e.g. bad weather, vacation, illness, maternity leave or family medical leave.
- ☐ I understand that if my child is to withdraw from the program, a two-week written notice must be provided to the Director of Childcare Services.
- ☐ I understand the Childcare Center's hours of operation for district employees are: 6:30 am to 5:15 pm on regular days, 6:30 a.m. to 4:00 p.m. on Early Dismissal days and 7:00 a.m. to 4:30 on Staff Development days.
- ☐ I understand a late fee of \$ 1.00 per minute will be charged if a child is picked up after 5:15 pm. The late fee will be collected via RevTrak.
- ☐ I understand that the Childcare Center reserves the right to terminate the enrollment of a child who is picked up late four (4) times within a school year.
- ☐ 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 reenroll.

- ☐ I understand the Galena Park I.S.D. Childcare Center reserves the right to deny services due to aggressive and/or unsafe behaviors of a parent or adult visitor without prior approval.
- ☐ I understand that it is my responsibility to keep the center advised of changes of addresses, phone numbers, and authorized pick-up information.
- ☐ I understand that if I choose 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.

Name of Child(ren)

Recipient Signature

Date

Role: Parent Caregiver/Employee Household Member (Ch. 747 only)

The GPISD Childcare Center Staff Signature

Date