

## 2020 Registration Form

Child's Name (last, first)	Date of Birth	Boy or Girl	Admission Date 2020
Street Address	City	Zip	Home Phone
Mom's Name or Legal Guardian	Cell Phone	Can we text you?	Work Phone
Mom's Email or Legal Guardian	Who is the Primary Contact (mom, dad, or other)?		
Dad's Name or Legal Guardian	Cell Phone	Can we text you?	Work Phone
Dad's Email or Legal Guardian	Special Circumstances:		
<input type="checkbox"/> I have reviewed the above information for accuracy. Any incorrect or missing information has been noted.			
_____ Signature – Parent or Legal Guardian			_____ Date

### Enrollment:

<b>Number of days per week your child will attend:</b> <input type="checkbox"/> 2 Days: T/Th <input type="checkbox"/> 3 Days: M/W/F <input type="checkbox"/> 4 Days: M-Th <input type="checkbox"/> 5 Days: M-F	Special Request: (based on availability only):
<b>How did you hear about us?</b> <input type="checkbox"/> Drive By <input type="checkbox"/> Internet Search <input type="checkbox"/> Friend, who can we thank: _____ <input type="checkbox"/> Other _____	
<b>Preferred Communication Method?</b> <input type="checkbox"/> Electronic Email <input type="checkbox"/> Electronic Text <input type="checkbox"/> Paper	

### Emergency Contact and Authorizations:

I hereby authorize Cornerstone MDO <i>to contact</i> the following person in case of an emergency, <b>only when</b> the parents cannot be reached:		
Name	Address	Phone
I hereby authorize Cornerstone MDO to allow my child <i>to leave</i> the childcare facilities <b>ONLY</b> with the following persons after verification of valid I.D. If no one is listed <b>AND</b> Cornerstone MDO is unable to reach parents, TX HHS will be called.		
Name	Phone	
Name		
Name		

### Authorization for Emergency Medical Attention:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize Cornerstone Mother's Day Out's designated employee to transport my child to:		
Physician's Name	Address	Phone Number
<b>Emergency Medical Care Facility</b> <b>Dell Children's Hospital or</b> <b>Nearest Hospital</b>	<b>Address</b> <b>4900 Mueller Blvd, Austin TX 78723</b> <b>Location to be chosen by EMS</b>	<b>Phone Number</b> <b>512-324-0000</b>
I give Cornerstone Mother's Day Out permission to secure any and all necessary emergency medical, hospital, or dental treatment for my child in the event of injury or illness while the child is in the care of the above named provider. <i>Note: I understand and agree that I would be financially responsible for any medical treatments necessary. I have full understanding that every attempt will be made to contact the parent or guardian in the event medical treatment is necessary. I understand that certain medical emergencies may not allow much time for contact of parent/guardian and that if a life-threatening situation arises, the provider will seek immediate medical attention.</i>		
_____ Signature – Parent or Legal Guardian		_____ Date

**Special Health Considerations:**

**Student:**

Does your child have any allergies? (food, animals, seasonal, etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, have these allergies been diagnosed by a health care professional <u>and determined to be potentially life threatening?</u> <i>(If yes, the Food Allergy and Anaphylaxis Emergency Care Plan form must be completed by your child's physician).</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What allergies does your child have and what are the triggers?		
How should we respond if he/she has an allergic reaction?		
Does your child have any non-allergy dietary restrictions? Please check any restrictions below: <input type="checkbox"/> Red Meat (Beef/Pork) <input type="checkbox"/> Chicken <input type="checkbox"/> Gluten <input type="checkbox"/> Dairy <input type="checkbox"/> Nuts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
My child is fully potty trained meaning they are able to communicate their need to use the restroom and has control until they reach the restroom.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, do you expect your child to be fully potty trained by the start of next school year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
List any special problems that your child may have, such as existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, special needs, and any other information which caregivers may need to be aware of:		

**Immunization Record:**

<p>Check all that apply</p> <p><input type="checkbox"/> I have provided Cornerstone MDO with a copy of my child's most current immunization record.</p> <p><input type="checkbox"/> I have provided a letter from my doctor stating the necessity for delaying immunizations.</p> <p><input type="checkbox"/> I will provide Cornerstone MDO with a copy of my child's most current immunization record before starting school.</p> <p><input type="checkbox"/> I have provided Cornerstone MDO with the Affidavit for Exemptions from Immunizations from the State of Texas.</p>
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**Vision and Hearing (Required for 4 and 5 year olds only)**

<p><input type="checkbox"/> My child does not require a vision and hearing test because they are not 4 years old by September 1<sup>st</sup> of the current school year.</p> <p><input type="checkbox"/> My child has had a vision and hearing and the results are attached.</p> <p><input type="checkbox"/> My child will get a vision and hearing before the start of school, or I will participate in Cornerstone MDO screening in the fall</p>
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**Healthcare Statement**

<p>One of the following must be presented within one week of your child being admitted to Cornerstone MDO.  <b>Please check only one option.</b></p> <p><input type="checkbox"/> A signed and dated copy of a health care professional's statement is attached.</p> <p><input type="checkbox"/> My child has been examined within the past year by a health care professional and is able to participate in a child day care program. Within 12 months of admission, I will obtain and submit to Cornerstone MDO a healthcare professional's signed statement. <i>(Note: Physician's name and address must be listed on the first page.)</i></p>	
<p>_____</p> <p>Signature – Parent or Legal Guardian</p>	<p>_____</p> <p>Date</p>

