German International School of Houston

German-English Dual Language Immersion Program

ONE CHILD. TWO LANGUAGES. UNLIMITED POSSIBILITIES

6221 Main Street, C110-C112, Houston, Texas 77030

Phone: 832-831-6843 - E-mail: office@gish-houston.org - www.gish-houston.org

Operation Name: ***German International School of Houston***		Director's Name: **Jessica Wood**	
Child's Full Name:		Child's Date of Birth: (mm/dd/yyyy)	Child's Home Phone #:
Child's Home Address (Street, City, Zip):			
Child Lives With: ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian	Custody Documents on File: ☐ Yes ☐ No	Date of Admission:	Date of Withdrawal:
Mother's Full Name or Legal Guardian's Full Name:	Address (Street, City, Zip) if different from child's address:		
Father's Full Name or Legal Guardian's Full Name:	Address (Street, City, Zip) if different from child's address:		

List telephone numbers below where Parents/Legal Guardians may be reached while child is in care:

Mother's/Legal Guardian Cell Ph. #:	Mother's/Legal Guardian Work Ph. #:	Father's/Legal Guardian Cell Ph. #:	Father's/Legal Guardian Work Ph. #:

IN CASE OF AN EMERGENCY, please contact FIRST:

☐ Mother ☐ Father ☐ Other: Phone #:

EMERGENCY CONTACT: In the event of an emergency and the Parents/Legal Guardian cannot be reached, I hereby authorize the child care operation to release my child to the Emergency Contact below (name, address and telephone number must be provided). The authorized person must present picture ID upon release of the child.

Full Name:	Home Phone #:
Address (Street, City, Zip):	Cell Phone #:
Relationship:	Work Phone #:

RELEASE AUTHORIZATION: Please list full name, cell phone number and relationship for each person authorized to pick up your child (do not include First and Emergency Contact):

I hereby authorize the child care operation to only release my child to the following persons (The Emergency Contact Person above is automatically included into the list below. Parents are required to notify the School via e-mail in case of a pick-up through a third party. Parents may only call the office regarding short notice changes in parent pick-up. For the safety of our students, our staff will call parents and wait for confirmation of arrangement if pick-up is not clearly communicated with the School. Please note that the ***German International School of Houston*** will not release the child without the necessary notice from the parent(s). In shared custody situations, it is the sole responsibility of the parent in charge to communicate the changes in pick-up with the other parent. Children will only be released to a parent or a person designated by the Parent/Legal Guardian after verification of ID)**:**

Full Name:	Cell Phone #:	**Relationship**:
Full Name:	Cell Phone #:	**Relationship**:
Full Name:	Cell Phone #:	**Relationship**:
Full Name:	Cell Phone #:	**Relationship**:
Full Name:	Cell Phone #:	**Relationship**:

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event of a medical emergency, or if I cannot be reached to make arrangements for medical care, I hereby authorize the person in charge to take my child to a Hospital or Emergency Medical Care facility. I give consent to the School to secure any and all necessary emergency medical care for my child. I prefer my child to be taken to the below designated Hospital or Emergency Medical Care facilities.

☐ **Texas Children's Hospital** 6621 Fannin St, Houston, TX 77030	☐ **Children's Memorial Hermann** 6411 Fannin St, Houston, TX 77030	☐ **Other:**

Signature Parent/Guardian:	**Date:**
Signature Parent/Guardian:	**Date:**

NAME OF CHILD:	**DATE OF BIRTH** (mm/dd/yyyy):

MEDICAL HISTORY: List any special needs that your child may have, such as **environmental allergies, food intolerances, tested allergies, existing illness, previous serious illness, injuries and hospitalizations** during the past twelve (12) months, any medication prescribed for long-term continuous use and any other information which caregivers should be aware of:

Existing Illness:	☐ No ☐ Yes	**Details:**	**Medication:**
Food Allergies (tested): **Plan submitted on: _____**	☐ No ☐ Yes	**Details:**	**Medication:**
Asthma:	☐ No ☐ Yes	**Medication:**	
Dietary Restrictions:	☐ No ☐ Yes	**Details:**	
Injuries/Hospitalization (in the last 12 months):	☐ No ☐ Yes	**Details:**	
Other:			

NOTE: Medication for asthma and food allergies such as inhaler, antihistamines and EpiPen must be in the original container and the prescription medication must have the RX labeling. A Food Allergy and Anaphylaxis Emergency Plan must be completed by the pediatrician before the first day of attendance and updated annually (https://www.foodallergy.org/faap).

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).

HEALTH STATEMENT: ADMISSION REQUIREMENT - Please choose one of the following options:

1. ☐ Signed and dated statement of a **HEALTHCARE PROFESSIONAL is attached.**

2. ☐ **PARENTS' AFFIDAFIT:**
Any medical diagnosis and treatment conflicts with the tenets or practices of a church or recognized religious denomination to which I adhere or are a member of.

3. ☐ **PARENTS' STATEMENT: My child has been examined within the past year by a healthcare professional and is able to participate in a daycare program. Within twelve (12) months of admission, I will obtain a healthcare statement signed by a healthcare professional, and will submit it to the child care operation.**

Name of Healthcare professional:	
Address:	**Phone #:**
Signature Parent/Guardian:	**Date:**
Signature Parent/Guardian:	**Date:**

TEMPORARY STUDENTS (ONLY): ELEMENTARY STUDENTS or SUMMER CAMP PRESCHOOL STUDENTS

My child attends the following School:

Address (Street, City, Zip):	Phone #:
☐	His/her immunization record, vision and hearing screening are on file at the school and all required immunizations are current.

SCHOOL DIRECTORY: I authorize the ***German International School of Houston*** to use the below information in the School's Directory to be shared with all enrolled families. No other information will be shared.

Parent 1:	**Parent 2:**	Zip Code:
Phone #:	Phone #:	
E-mail:	E-mail:	

NAME OF CHILD:	**DATE OF BIRTH** (mm/dd/yyyy):

PLEASE CHECK ALL THAT APPLY:

1. Water Activities:	**I hereby give** my consent for my child to participate in the following water activities:	☐ water table play ☐ sprinkler play ☐ aquatic playgrounds ☐ splashing/wading pools
2. Meals: ☐	I understand that I am responsible to provide my child with a nutritional balanced meal and snack for After Care (if applicable). The ***German International School of Houston*** does not provide meals for children in its care.	
3. Transportation: ☐	I acknowledge that the ***German International School of Houston*** will not provide transportation for my child in case of an emergency. An ambulance will be called if emergency care is needed, and parents are responsible for any charges that may occur.	
4. Archway Academy: ☐	I hereby acknowledge that I have been informed that the ***German International School of Houston*** is situated at the same physical address as Archway Academy (www.archwayacademy.com).	

INSECT REPELLENT SPRAY / SUNSCREEN LOTION/SPRAY / OVER THE COUNTER MEDICATION

1. Insect Repellent:	**I hereby** ☐ **give** ☐ **do not give**	my consent to apply on my child an insect repellent ☐ provided by the School. The School will use **Babyganics** (Natural Insect Repellent Pump Spray, DEET-free, without parabens, sulfates, phthalates, artificial fragrances or dyes). I have made myself familiar with the active ingredients: ☐ Yes ☐ provided by me.
2. Sunscreen:	**I hereby** ☐ **give** ☐ **do not give**	my consent to apply on my child a sunscreen lotion/spray ☐ provided by the School. The School will use **Babyganics SPF 50+** (Sunscreen Pump Spray, Octinoxate 7.5%, Octisalate 5.0%, Zinc Oxide 11.2%; formulated without PABA, phthalates, parabens, fragrances and nano-particles). I have made myself familiar with the active ingredients: ☐ Yes ☐ provided by me.
3. Over the Counter Medication:	**I hereby** ☐ **give** ☐ **do not give**	my consent to apply on my child **Aquaphor** Advanced Therapy Healing Ointment (Petrolatum 41%). I have made myself familiar with the active ingredients: ☐ Yes
	I hereby ☐ **give** ☐ **do not give**	my consent to apply on my child **Benadryl Extra Strength** Itch Stopping Cream (Diphenhydramine Hydrochloride 2%, Zink Acetate 0.1%). I have made myself familiar with the active ingredients: ☐ Yes

IMMUNIZATION RECORD, VISION/HEARING SCREENING:

☐	I have provided the child care operation with a copy of my child's most current immunization record. Families moving to the United States from a different country must compare the immunization standards of both countries (www.dshs.state.tx.us/immunize/public.shtm).
☐	I have attached a signed and dated affidavit stating that I decline immunization for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than ninety (90) days after the affidavit is notarized. I understand that this affidavit is valid for two (2) years. This exempt form can be obtained at: http://webds.dshs.state.tx.us/immco/affidavit.shtm.
☐	I have attached a signed and dated affidavit stating that the vision and/or hearing screening conflicts with the tenets or practices of a church or religious denomination to which I adhere or are a member of.

Varicella (Chickenpox): Immunization Is not required if your child has had the chickenpox disease.

My child had varicella (chickenpox) on/in _____ (date/year) and does not need the varicella vaccine.

Signature Parent/Guardian:	**Date:**
Signature Parent/Guardian:	**Date:**

HEALTH STATEMENT and VISION/HEARING SCREENING FORM

Please submit this form completed by your child's physician:

NAME OF CHILD:	**DATE OF BIRTH** (mm/dd/yyyy):

HEALTH STATEMENT:

HEALTHCARE PROFESSIONAL'S STATEMENT: **I have examined the above child within the past year and find that he or she is able to take part in a daycare/preschool program.**

Office Stamp of physician or public health personnel:	_____ **Healthcare Professional's Signature** _____ **Date**

VISION SCREENING: **Vision and Hearing Screening is a requirement by Child Care Licensing for all students four (4) years of age. Results have to be submitted within three (3) months after the child's fourth (4th) birthday.**

VISION	**R 20/ _____**	**L 20/ _____**	☐ **PASS** ☐ **FAIL**

Office Stamp of physician or public health personnel:	_____ **Healthcare Professional's Signature** **Please provide office stamp on the left.** _____ **Date**

HEARING SCREENING: **Vision and Hearing Screening is a requirement by Child Care Licensing for all students four (4) years of age. Results have to be submitted within three (3) months after the child's fourth (4th) birthday.**

HEARING	**1000 Hz**	**2000 Hz**	**4000 Hz**	
R				☐ **PASS** ☐ **FAIL**
L				☐ **PASS** ☐ **FAIL**

Office Stamp of physician or public health personnel:	_____ **Healthcare Professional's Signature** **Please provide office stamp on the left.** _____ **Date**

IMMUNIZATION FORM

Please submit this form completed by your child's physician or provide a signed copy of your child's current immunization record.

NAME OF CHILD:	**DATE OF BIRTH** (mm/dd/yyyy):

IMMUNIZATION RECORD		
Vaccine	**Vaccine Schedule**	**Dates Child Received Vaccine**
Hepatitis B	Birth (first dose)	
	1-2 months (second dose)	
	6-18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15-18 months (fourth dose)	
	4-6 years (fifth dose)	
Haemophilus Influenzae Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12-15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12-15 months (fourth dose)	
Inactive Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6-18 months (third dose)	
	4-6 years (fourth dose)	
Influenza	Yearly, starting at 6 months	
	Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12-15 months (first dose)	
	4-6 years (second dose)	
Varicella	12-15 months (first dose)	
	4-6 years (second dose)	
Hepatitis A	12-23 months (first dose)	
	Second dose should be given 6-18 months after the first dose.	

Physician/Public Health Personnel Verification: Signature and stamp of physician or public health personnel verifying immunization above		
Signature:	**Office Stamp:**	**Date:**