



Holy Comforter Episcopal School

2024-2025

Enrolling Children Ages 2 through 5



Child's Name: _____ Date of Birth: _____

3 Day Program

Monday, Wednesday, Friday

Tuition Bills Monthly

8:00-12:00 \$290.00

8:00-2:30 \$370.00

8:00-5:30 \$480.00

Add Early Drop-Off \$35.00

5 Day Program

Monday—Friday

Tuition Bills Monthly

8:00-12:00 \$400.00

8:00-2:30 \$510.00

Add Early Drop-Off \$35.00

Full Time 7:00-5:30 \$345.00 Tuition Bills Bi-Weekly

Kindergarten Monday-Friday 8:00-3:00 \$565.00, 8:00-5:30 \$690.00

*This class is contingent on student enrollment; HCES will notify you by 7/31/2024 if the class does not make.

*Fees

Registration: New Student \$100.00 Returning Student \$75.00

Supply Fee: \$240.00 (May be paid in 4 scheduled increments)

**Mat Fee: \$40.00 (For new students who stay beyond 12:00)

*Fees are non-refundable

**One time fee; students returning to the lunch bunch program need not pay again.

Holy Comforter Episcopal School

Student Admission Information 2024-2025

T. Annette Jones, Director

CHILD'S INFORMATION

Child's Full Name:	Child's Date of Birth:	Child's Gender:
Child's Home Address:		
Child Lives With: <input type="checkbox"/> Both parents <input type="checkbox"/> Guardian <input type="checkbox"/> One parent, indicate with whom the child lives _____		
Custody Documents on File? <input type="checkbox"/> Yes <input type="checkbox"/> No		

3 Day Program	5 Day Program (Part-Time)	5 Day Program (Full-Time)	Kindergarten (5 Days)
<input type="checkbox"/> 8-12 <input type="checkbox"/> 8-2:30 <input type="checkbox"/> 8-5:30	<input type="checkbox"/> 8-12 <input type="checkbox"/> 8-2:30	<input type="checkbox"/> 7-5:30	<input type="checkbox"/> 8-3 <input type="checkbox"/> 8-5:30

PARENT OR GUARDIAN INFORMATION

Name:	Name:
Address (if different):	Address (if different):
Cell #: Work #:	Cell #: Work #:
Employer:	Employer:
Email:	Email:

In case of an emergency and parents/guardians cannot be reached, call:

Name:	Relation to child:	Phone #:
Address:		

AUTHORIZED PICK UP

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:	Phone #:	Relation:
Name:	Phone #:	Relation:
Name:	Phone #:	Relation:

For Office Use Only Date of Admission: _____
Date of Withdrawal: _____

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 #
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Name of Emergency Care Facility	Address	Phone #
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I give consent for the facility to secure any and all necessary emergency medical care for my child.
I give consent for my child to be transported and supervised by the operation's employee for emergency care.

Signature—Parent or Legal Guardian **Date**

CHILD'S SPECIAL CARE NEEDS (Check all that apply)

<input type="checkbox"/> Environmental Allergies	<input type="checkbox"/> Injuries & Hospitalizations (past 12 months)	<input type="checkbox"/> Symptoms or Indications of Complications
<input type="checkbox"/> Food Intolerances	<input type="checkbox"/> Limitations or Restrictions on child's activities	<input type="checkbox"/> Medications prescribed for long-term use
<input type="checkbox"/> Existing Illness	<input type="checkbox"/> Reasonable Accommodations or Modifications	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Previous Serious Illness	<input type="checkbox"/> Adaptive Equipment (include instructions below)	<input type="checkbox"/> No Known Allergies or Special Care Needs

Explain any needs selected:

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 1-800-514-0301 (voice) 1-800-514-0383 (TTY).

Signature—Parent or Legal Guardian **Date**

ADMISSION REQUIREMENTS

Health Care Professional's Statement stating that your child has been examined within the past year and is able to participate in the day care program. This form (found on the last page of this packet) must be signed and dated by a health care professional.

Immunization Record, up to date and verified with a signature or stamp of a physician or public health personnel, as well as, dated.

REQUIREMENTS FOR EXCLUSION FROM COMPLIANCE

I have attached a signed and dated affidavit stating that I decline immunizations for reasons of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

I have attached a signed and dated affidavit stating that the vision and hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

RECEIPT OF WRITTEN OPERATIONAL POLICIES

I acknowledge receipt of the facility's operational policies, including:

Discipline and Guidance	Procedures for release of children
Suspension and Expulsion	Illness and exclusion criteria
Emergency Plans	Procedures for dispensing medications
Procedures for conducting Health Checks	Immunization requirements for children
Safe Sleep (not applicable to HCES)	Meals and food service practices
Procedures for parents to discuss concerns with the director	Procedures for supporting inclusive services
Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions	Procedures for parents to contact CCR, DFPS, Child Abuse Hotline, and CCR website
Procedures for parents to participate in operation activities	

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

These may be found in our Parent Handbook.

MEALS

I understand that the following meals will be served to my child while in care:

HCES will serve all children a morning snack. An afternoon snack will be served to full time children. Each snack will be served with 1% cow's milk unless indicated in the special care needs section on the previous page. All snacks served are in compliance with CACFP standards. Parents of lunch bunch and full time children will provide a ready to eat lunch for their child.

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

Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming? Yes No

Do you want your child to wear a life jacket while in or near a swimming pool? Yes No

STATEMENTS

Holy Comforter is a 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.

Health and Human Services values your privacy. For more information, read their privacy policy online at: <https://hhs.texas.gov/policies-practices-privacy#security>

SIGNATURES

Child's Parent or Legal Guardian

Date

Center Designee

Date

Child's Full Name: _____ Date of Birth: _____

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, the following must be presented when your child is admitted to the child-care operation or within one week of admission.

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.

Signature-Health Care Professional

Date

VISION & HEARING EXAM RESULTS:

(Required for all children 4 years old or turning 4 before September 1st)

Right Eye 20/	Left Eye 20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
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Signature:	Date:
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Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Left				<input type="checkbox"/> Pass <input type="checkbox"/> Fail

Signature:	Date:
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For Requirements for Exclusion from Compliance please see page 3 of the admission packet.

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

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 (chicken pox) on or about _____ Date and does not need varicella vaccine.

Signature-Parent or Legal Guardian

Date