



# Coker UMC Early Learning Center

231 E. North Loop Rd.  
San Antonio, TX 78216-1812  
210-494-4481 / 210-494-5061  
Fax 210-494-8537

**ADMISSION REQUIREMENT:** All students enrolling in Coker UMC Early Learning Center must have this health certificate completed and signed by parent within one week of admission.

Child's Name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last) (First)

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Parents' Name(s) \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

\*\*\*\*\*

**AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:**

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

Name of Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone# \_\_\_\_\_

Emergency Medical Care Facility \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

I give consent for the facility to secure any and all necessary emergency medical care for my child:

\_\_\_\_\_  
Signature of parent/legal guardian

List any special conditions that your child may have such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:

\_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*

**ADMISSION REQUIREMENT:** One of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

PLEASE CHECK ONLY ONE OPTION:

1. \_\_\_\_\_ 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.

\_\_\_\_\_  
Health Care Professional's Signature

\_\_\_\_\_  
Date

2. \_\_\_\_\_ A SIGNED AND DATED COPY OF A HEALTH CARE PROFESSIONAL'S STATEMENT IS ATTACHED.

3. \_\_\_\_\_ MEDICAL DIAGNOSIS AND TREATMENT CONFLICT WITH THE TENETS AND PRACTICES OF A RECOGNIZED RELIGIOUS ORGANIZATION, WHICH I ADHERE TO OR AM A MEMBER OF; I HAVE ATTACHED A SIGNED AND DATED AFFIDAVIT STATING THIS.

4. \_\_\_\_\_ MY CHILD HAS BEEN EXAMINED WITHIN THE PAST YEAR BY A HEALTH CARE PROFESSIONAL AND IS ABLE TO PARTICIPATE IN THIS DAY CARE PROGRAM. WITHIN 12 MONTHS OF ADMISSION, I WILL OBTAIN A HEALTH CARE PROFESSIONAL'S SIGNED STATEMENT AND WILL SUBMIT IT TO THE FACILITY.

**NAME AND ADDRESS OF HEALTH CARE PROFESSIONAL:**

\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PARENT OR LEGAL GUARDIAN  
(over)

**IMMUNIZATIONS (All are required.)**

	Date/Dose 1	Date/Dose 2	Date/Dose 3	Date/Booster	Date/Booster
Hepatitis B					
DtaP					
Polio					
MMR					
Hib					
Hepatitis A (2 doses required)					
Pneumococcal Conjugate					
Varicella (Chicken Pox)	Date of Vaccine:	Date of 2 <sup>nd</sup> Dose:	Date of Disease:		
TB Test (Dr.'s Option)					

(A copy of your child's up-to-date shot record can be attached.)

**HEARING AND VISION SCREENING  
(REQUIRED FOR CHILDREN 4 YEARS AND OLDER)**

**HEARING SCREENING:**

	Right	Left
25db		
500 Hz		
1000 Hz		
2000 Hz		
4000 Hz		

**VISION SCREENING:**

Distance acuity: R: 20/\_\_\_\_ L: 20/\_\_\_\_

\_\_\_\_ Pass          \_\_\_\_ Fail

\_\_\_\_ Child wears glasses

\_\_\_\_ Pass \_\_\_\_ Fail \_\_\_\_ Wears hearing aid

**IN THE EVENT OF AN EMERGENCY AND IN MY ABSENCE, I HEREBY GIVE CONSENT TO ANY OF THE COKER UNITED METHODIST CHURCH STAFF AND/OR VOLUNTEER STAFF TO SEEK EMERGENCY MEDICAL TREATMENT FOR MY CHILD NAMED ABOVE. WHILE UNDERSTANDING THAT ALL REASONABLE SAFETY PRECAUTIONS WILL BE OBSERVED, I UNDERSTAND THE POSSIBILITY OF UNFORESEEN HAZARDS AND THE INHERENT POSSIBILITY OF RISK. I VOLUNTARILY AGREE NOT TO HOLD LEGALLY LIABLE COKER UNITED METHODIST CHURCH, ANY OF ITS EMPLOYEES, VOLUNTEERS, OR OTHER REPRESENTATIVES ASSOCIATED WITH PROVIDING OR ARRANGING FOR EMERGENCY MEDICAL TREATMENT FOR MY CHILD.**

\_\_\_\_\_  
PARENT'S SIGNATURE

\_\_\_\_\_  
DATE