

School Kids In PeterboroughNew Contract Returning Family [SKIP Only: Contract received date]Parent/Guardian Name(s): Address: Town/State/Zip: Telephone: H C W E-mail: H W Parent/Guardian Name(s): Address: Town/State/Zip: Telephone: H C W E-mail: H W Check One: I prefer electronic billing at the H / W (select one) email above via brightwheel I prefer to pick up a paper bill (emails will still be sent via brightwheel)**I hereby contract with School Kids In Peterborough to provide childcare for the listed children on a monthly basis for the remainder of the 25/26 school year session.**Child's Name: Age: Date of birth: Grade: Teacher: My child has an I.E.P. or 504 plan: On non-SKIP days my child will get home by: Bus Pickup Walk Combo Registration Fee \$50 Drop-in Only: Contract Start Date:

	Monday	Tuesday	Wednesday	Thursday	Friday	Cost
Before School	<input type="checkbox"/>					
After School	<input type="checkbox"/>					

Child's Name: Age: Date of birth: Grade: Teacher: My child has an I.E.P. or 504 plan: On non-SKIP days my child will get home by: Bus Pickup Walk Combo Registration Fee \$45 Drop-in Only: Contract Start Date:

	Monday	Tuesday	Wednesday	Thursday	Friday	Cost
Before School	<input type="checkbox"/>					
After School	<input type="checkbox"/>					

By signing this form I claim financial responsibility to pay the weekly total per child on a monthly basis according to the terms and policies (outlined in the 25/26 school year handbook) as contracted above. Please read our financial policies carefully as late fees/termination may apply if payment is not made prior to service.

Signature: Date: Signature: Date:

School Kids In Peterborough

Additional Children

I hereby contract with School Kids In Peterborough to provide childcare for the listed children on a monthly basis for the remainder of the 25/26 school year session.

Child's Name: _____ Age: _____ Date of birth: _____

Grade: _____ Teacher: _____ My child has an I.E.P. or 504 plan: _____

On non-SKIP days my child will get home by: Bus _____ Pickup _____ Walk _____ Combo _____

Registration Fee \$45 Drop-in Only: _____ Contract Start Date: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Cost
Before School						
After School						

Child's Name: _____ Age: _____ Date of birth: _____

Grade: _____ Teacher: _____ My child has an I.E.P. or 504 plan: _____

On non-SKIP days my child will get home by: Bus _____ Pickup _____ Walk _____ Combo _____

Registration Fee \$45 Drop-in Only: _____ Contract Start Date: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Cost
Before School						
After School						

By signing this form I claim financial responsibility to pay the weekly total per child on a monthly basis according to the terms and policies (outlined in the 25/26 school year handbook) as contracted above. Please read our financial policies carefully as late fees/termination may apply if payment is not made prior to service.

Signature: _____ Date: _____

Signature: _____ Date: _____

Permissions:

_____ I allow ConVal staff and SKIP to share their knowledge and information regarding the behavioral or educational needs of my child(ren).

_____ I allow transfer of my child's health information and forms between the ConVal school district and SKIP site director.

I, _____ (parent's name) give the following permission to School Kids In Peterborough to use photos of my child(ren). _____

For the possible purpose of promoting our program, encouraging volunteers, creating promotional materials, or for use in posts on our website, social media, or in local newspapers. (We never use last names)

- I allow my child's first name to be used. (rarely use any names)
- I allow unnamed photos of my child to be used.
- I do not want photos of my child used in any way.

NAME OF CHILD CARE PROGRAM: School Kids in Peterborough

LICENSE NUMBER

TO THE PARENT OR GUARDIAN: This form must be completed for each of your children who will be enrolled in the program, and must be updated whenever information changes.

DATE OF CHILD'S ENROLLMENT

Child's name:	Date of birth:
Address:	Phone number:

IDENTIFYING INFORMATION OF PARENT/S OR GUARDIAN/S LEGALLY RESPONSIBLE FOR CHILD:

Name:	Name:
Address:	Address:
Home phone number:	Home phone number:
Indicate where parent/guardian above can be reached while child is in care. Include name, address and phone number of business if applicable. Include any special instructions, e.g. pager, cell phone, etc.	
Business Name:	Business Name:
Address:	Address
Phone number:	Hours:
Email:	Email:
Special Instructions for reaching parent/guardian:	

EMERGENCY CONTACT PERSON: You (parent/guardian) are required to list at least 1 person with whom you would feel comfortable leaving your child, and who could assume responsibility for your child if you could not be reached immediately in an emergency, or if for some reason you could not pick up your child and were unable to communicate with the program. Examples: if your child were sick and you were not accessible, or if you experienced sudden illness between work and picking up your child.

Name:	Name:
Relationship:	Relationship:
Address:	Address:
Phone number:	Phone number:

NON-EMERGENCY ALTERNATE PICK-UP PERSON/S: I,

(Parent/Guardian Signature)

authorize the following individual(s) to pick up my child from the program on a non-emergency basis.

Name:	Name:
Relationship:	Relationship:
Address:	Address:
Phone number:	Phone number:

NOTE TO PARENT/S or GUARDIAN/S:

The licensing authority for this program is the bureau of licensing and certification, child care licensing unit. Child care programs are required to post a copy of the statement of findings and corrective action plan for the most recent visit in a location which is accessible to parents, and must maintain copies of the statement of findings and corrective action plan for the preceding visit and make them available for parents to review upon request, statements of findings and corrective action plans are also available online at

<https://nhlicenses.nh.gov/verification/Search.aspx?facility='Y> or by calling the unit at 603-271-9025 or 1-800-852- 3345, extension 9025. During visits to programs, licensing staff speak with children regarding the care they receive at the program if in the judgment of the licensing staff the children's response would be valuable in determining compliance with licensing rules. Licensing staff are experienced in working with children and trained to speak with children in a manner that is respectful and non-leading. Children will remain with their class or group during these conversations with licensing staff, and at no time will a child be forced to speak with a licensing coordinator. Please indicate whether licensing staff may speak with your child while they are with their class or group:

I give permission for child care licensing staff to speak with my child while with their class or group.

I do not give my permission for child care licensing staff to speak with my child while with their class or group.

If licensing staff believes your child may have specific information regarding an alleged event at the child care program, and determines that it is best to interview your child separately and not with their class or group, please indicate your preference among the following options:

- I give permission for child care licensing staff to interview my child at the child care program separate from their class or group.
- I wish to be notified prior to child care licensing staff interviewing my child at the child care program separate from their class or group.
- I do not give permission for child care licensing staff to interview my child at the child care program separate from their class or group.

For more information about Child Care Licensing please visit our website at: <https://www.dhhs.nh.gov/programs-services/childcare-parenting-childbirth/child-care-licensing>

MEDICAL INFORMATION

Any chronic conditions, allergies or medications that could be important in case of sudden illness or injury:

Child's Usual Physician:

Phone number:

Physician's Address:

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

I hereby give permission for the staff of School Kids In Peterborough to provide simple first aid treatment to my child, _____ when necessary. In the event of a more serious illness or injury, I give permission for my child to be transported to a hospital or other emergency medical facility to receive emergency medical treatment. I also authorize ambulance/rescue squad attendants to administer such treatment as is medically necessary, and I authorize licensed health practitioners working in the hospital or emergency medical facility to examine and provide emergency medical treatment to my child if warranted. I understand that I will be contacted by child care program personnel as soon as possible regarding any emergency involving my child.

Parent/Guardian Signature

Date

ANNUAL UPDATE: Make necessary changes & initial & date below to verify that the information is current.

Parent/Guardian Initials:	Date:	Parent/Guardian Initials:	Date:
Parent/Guardian Initials:	Date:	Parent/Guardian Initials:	Date:

School Kids In Peterborough

Please fill out this section for OTC meds only.

We have a separate form if the need for prescription medication arises. We do ask that you avoid the need for daily prescription meds to be administered at SKIP when at all possible. If your child needs an inhalers or epipen please notify us so we can get you the correct forms.

AUTHORIZATION TO ADMINISTER PRESCRIPTION AND NON PRESCRIPTION MEDICATION

IN ACCORDANCE WITH HE C 4002.18, THIS FORM MUST BE COMPLETED PRIOR TO THE ADMINISTRATION OF ANY PRESCRIPTION OR NON-PRESCRIPTION MEDICATION.

NON-PRESCRIPTION MEDICATION MUST BE IN ORIGINAL CONTAINER, AND WILL BE ADMINISTERED IN ACCORDANCE WITH THE MANUFACTURER'S PRINTED INSTRUCTIONS. IF THERE ARE NO MANUFACTURER'S PRINTED INSTRUCTIONS FOR THE AGE OF THE CHILD, THE PROGRAM MAY ADMINISTER THE NON-PRESCRIPTION MEDICATION IN ACCORDANCE WITH THE WRITTEN, DATED AND SIGNED INSTRUCTIONS FROM THE CHILD'S PARENT, INCLUDING A STATEMENT THAT THE INSTRUCTIONS HAVE BEEN REVIEWED/APPROVED BY THE CHILD'S LICENSED HEALTH PRACTITIONER, OR WITH SIGNED, DATED WRITTEN INSTRUCTIONS FROM CHILD'S LICENSED HEALTH PRACTITIONER.

I do not authorize administration of any medications to my child while at SKIP

PARENT'S AUTHORIZATION

I AUTHORIZE CHILD CARE PERSONNEL AT School_Kids_In_Peterborough TO ADMINISTER THE
NAME OF CHILD CARE PROGRAM

FOLLOWING MEDICATION TO MY CHILD: CHILD'S NAME DATE OF BIRTH

NAME OF MEDICATION	DOSAGE or weight of child	TIMES TO ADMINISTER	BEGINNING DATE	ENDING DATE
Tylenol (or generic)				
Ibuprofen				
Benedryl (or generic)				

PRINTED NAME AND PHONE NUMBER OF CHILD'S LICENSED HEALTH PRACTITIONER

PARENT/GUARDIAN'S SIGNATURE DATE SIGNED

SPECIAL INSTRUCTIONS FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION:

Call me first at (phone number)

THE ABOVE SPECIAL INSTRUCTIONS WERE: REVIEWED AND APPROVED BY THE ABOVE NAMED LICENSED HEALTH PRACTITIONER
COMPLETED BY THE LICENSED HEALTH PRACTITIONER WHO'S SIGNATURE IS BELOW

LICENSED HEALTH PRACTITIONER'S SIGNATURE DATE SIGNED

Health Information: Please note each child

Operations / Serious injuries:

Chronic or recurring illness:

Dietary restrictions:

Learning / Behavioral needs:

If your child has an I.E.P. or 504 plan, please include a copy for us.

School Kids In Peterborough

Health Information continued: Please note each child

Physical, Social, Emotional, or Sensory needs:

Activity limitations or special conditions to be aware of:

VERY IMPORTANT

Allergies to food, drugs, insects, plant/pollen, animal, or other:

Tell us about your Skipper(s):

Any information that you can share with us to make your child more comfortable at SKIP is greatly appreciated and valued. It's our goal to make every child's stay at SKIP as positive an experience as possible.

What 3 things does your child want us to know about them?:

What 3 things do you want us to know about your child?:

What things does your child not like?:

Things I expect from SKIP:

Please list any concerns you may have:

Any other info you'd like to share with us:

Please be sure to fill out the next 3 pages for the CACFP completely. This is a requirement to participate in the SKIP program as we rely on programs like this to continue providing the services you expect.

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:
Insert URL Here

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

STEP 2	Do any household member's (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?
IF NO > Go to STEP 3 IF YES > Write case number here and proceed to STEP 4 (do not complete STEP 3)	CASE NUMBER: <small>Write only one case number in this space.</small>
STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)	

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Write only one case number in this space.

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

B. All Adult Household Members (including yourself) even if they do not receive income from
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income from each source in whole dollars (no cents) only. If they do not receive income from

The "Sources of Income for Children" chart will help you with the Child Income section.

Total Household Members (Children and Adults)

Primary Wage Earner or other Adult Household Member

Check if no SSN

STEP 4 Contact information and adult signature. MAIL COMPLETED FORM TO YOUR SCHOOL AT

"certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form _____

Address _____
City _____ State _____ Zip _____
Phone/Email _____

Source of Income for Children	
Sources of Child Income	Examples
Earnings from work	<ul style="list-style-type: none"> A child has a regular full or part-time job where they earn a salary or wages
Social Security <ul style="list-style-type: none"> - Disability Payments - Survivors Benefits 	<ul style="list-style-type: none"> A child is blind or disabled and receives Social Security benefits A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	<ul style="list-style-type: none"> A friend or extended family member regularly gives a child spending money
Income from any other source	<ul style="list-style-type: none"> A child receives regular income from a private pension fund, annuity, or trust

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your child's eligibility for receiving meals during care.

Ethnicity (check one): Hispanic or Latino Not Hispanic or Latino

Race (check one or more): American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We **MA**y share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

Source of Income for Adults	
Earnings from Work	Public Assistance/Alimony/Child Support
Net income from self-employment (farm or business)	<ul style="list-style-type: none"> Unemployment benefits Workers compensation Supplemental Security Income (SSI) Cash assistance from State or local government Alimony payments Child support payments Veterans benefits Strike benefits
If you are in the U.S. Military:	<ul style="list-style-type: none"> Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) Allowances for off-base housing, food, and clothing Rental income Regular cash payments from outside household
	<ul style="list-style-type: none"> Social Security (including railroad retirement and black lung benefits) Private pensions or disability benefits Income from trusts or estates Annuities Investment income Earned interest Rental income Regular cash payments from outside household

DO NOT FILL OUT For official use only

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

***Only use this address if you are filing a complaint of discrimination.**

Total Income	How often?	Eligibility	Pensions/Retirement/ All other sources of income
<input type="text"/>	<input type="radio"/> Weekly <input type="radio"/> Bi-Weekly <input type="radio"/> Monthly <input type="radio"/> 2x Month	<input type="radio"/> Free <input type="radio"/> Reduced <input type="radio"/> Denied	Social Security (including railroad retirement and black lung benefits) Private pensions or disability benefits Income from trusts or estates Annuities Investment income Earned interest Rental income Regular cash payments from outside household
Determining Official's Signature	Date	Confirming Official's Signature	Date

**Child and Adult Care Food Program
CHILD ENROLLMENT FORM**

Dear Parent:

Your child(ren)'s child care has been approved for participation in the USDA's Child and Adult Care Food Program, which partially reimburses Child Care Providers/Centers for nutritious meals served to children in attendance. This program reimbursement supports the quality of the meal program and is beneficial to you and your child(ren) because it provides nutritious meals and snacks.

Sponsoring Organization Name: **Southern NH Services, Inc**
Sponsoring Organization Phone #: (603) 668-8010
Child Care Provider/Business Name:

Sponsoring Organization CACFP
Representative Name: Amy Allen

Annual Renewals:

Check One:

I certify that the changes noted, initiated and dated below are true and accurate.

I certify that the information recorded below remains true and accurate.

Parent/Guardian Signature: _____ Date: _____

Directions: Form must be completed by parent/guardian so that the actual time of enrollment reflects the accurate arrival and departure times each day of the child(ren) in attendance. Please ensure that this document represents the most current profile of your child(ren)'s enrollment status. Update and certify this document annually.

SKID Will Fill out this screen Box

Full Name of Child(ren) in Family Enrolled in CACFP	Date of Birth	Age	Time Child Arrives at Day Care	Time Child Goes to School	Time Child Returns from School	Time Child Leaves Home	Days in Care						Attendance during Vacation/No-School Days (Circle One)	Meals Eaten at Child Care					
							M	T	W	Th	F	Sa	Su	Bk	AM Sn	L	PM Sn	Su	BT Sn
/ /														Y N	X	X	X		
/ /														Y N	X	X	X	X	
/ /														Y N	X	X	X	X	
/ /														Y N	X	X	X	X	
/ /														Y N	X	X	X	X	
/ /														Y N	X	X	X	X	
/ /														Y N	X	X	X	X	
														Y N	X	X	X	X	

Please Print

Parent/Guardian Names

Mailing Address

Home Phone #

Parent/Guardian Workplaces:

Mother Phone #

Father Phone #

To the best of my knowledge all of the above information is correct.

Sponsor Signature

Parent/Guardian Signature

Effective Date of Form:

Check One

New Enrollment Annual Renewal