School Kids In Peterborough

2026-2027 Contract

New Contract____ **Returning Families** __ Fill out page 1 and permissions on the bottom of 2 ONLY, unless there are changes to make to the remaining pages.

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_____

I hereby contract with School Kids In Peterborough to provide childcare for the listed children on a monthly basis for the remainder of the 26/27 school year session.

Child's Name:_____Age:____Date of birth:_____

Grade:____Teacher:_____My child has an I.E.P. or 504 plan:_____

Registration Fee $50 Drop-in Only:_____Contract Start Date:_____

18$ a session	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:_____

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School Kids In Peterborough

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.

Additional Children

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.

CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

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 childcare licensing staff to speak with my child while with their class or group.

☐ I do not give my permission for childcare 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 childcare 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 childcare licensing staff to interview my child at the childcare program separate from their class or group.

☐ I wish to be notified prior to childcare licensing staff interviewing my child at the childcare program separate from their class or group.

☐ I do not give permission for childcare licensing staff to interview my child at the childcare program separate from their class or group.

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:

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

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.

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				
Benadryl (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:

School Kids In Peterborough

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NAME OF CHILD CARE PROGRAM: School Kids in Peterborough LICENSE NUMBER: 04702

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:	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: