New 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 24/25 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						
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 24/25 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:_____

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 24/25 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 24/25 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.

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.
- ☐ 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

School Kids In Peterborough

04702

NAME OF CHILD CARE PROGRAM

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:	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:

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.

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)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Check all that apply

STEP 2 Do any household members (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:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

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

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

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

B. All Adult Household Members (Including yourself)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X X X

Check if no SSN ☐

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

"I 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 | Signature of Adult | Today's Date

Address | City | State | Zip | Phone/Email

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• 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	• A friend or extended family member reguarly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• 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

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 children'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 not, 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 MAY 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.

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.ascr.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

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

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

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

Total Income

How often?

Weekly	Bi-Weekly	Monthly	2x Month
○	○	○	○

Household size

Categorial Eligibility ☐

Eligibility

Free	Reduced	Denied
○	○	○

Determining Official's Signature | Date | Confirming Official's Signature | Date | Follow-up 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, initialed 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.***

* SKIP Will Fill out this Green 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 for Home	Days in Care M	T	W	Th	F	Sa	Su	Attendance during Vacation/ No-School Days (*Circle One*)	Meals Eaten at Child Care Bk	AM Sn	L	PM Sn	Su	BT Sn
	/ /													Y N						
	/ /													Y N						
	/ /													Y N						
	/ /													Y N						
	/ /													Y N						
	/ /													Y N						

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.

Parent/Guardian Signature

_____

Date _____

For CACFP Representative Use Only

Sponsor Signature

_____

Effective Date of Form: _____

Check One

( ) New enrollment *( ) Annual Renewal*

Non-Discrimination Statement: *This explains what to do if you believe you have been treated unfairly. In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington DC 20250-9410 or call (800)795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.*