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Thank you for taking the time to read our registration materials. By signing this form, you acknowledge that you have read our materials and understand when SKIP will be open and closed, and that you understand our special contract day policy, behavior policy, financial policy, rates, and snow day policy. Of course, we are happy to answer any new questions that may arise at any time! Thank you for sharing your child with us!

I,	have read
and understand all registration materials	5.
	Pedig
(signature) (c	date)



Kids In Peterborough

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. You must also either complete a new form annually, or update this form annually by following the instructions at the bottom of the reverse side of this form.

Child's name:	Date of birth:
Address:	Phone number:
A the vinitarian of the place and the contract of the	The transfer of the second of
	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 reache business if applicable. Include any special instruction	d while child is in care. Include name, address and phone number of
Business Name:	Business Name:
Address:	Address
Phone number: Hours:	Phone number: Hours:
would feel comfortable leaving your child, and who	could assume responsibility for your child if you could not be reached
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CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

		PERSON/S Continued	
Name:	y and a way	Name:	
Relationship:		Relationship:	
Address:		Address:	
Phone number:		Phone number:	
Certification, Child Care Licensic corrective action plan for the mostatement of findings and corrective upon request. Statements http://childcaresearch.dhhs.nh.go During licensing, monitoring, and children regarding the care they response would be valuable in dwith children and trained to interchild interviewed, or if you wish provider, center director, site of preference.	ing Unit. Child care ost recent visit in a le ctive action plan fo of findings ar ov or by calling the and complaint invest y receive at the pro- letermining complia erview in a manner a to be informed price director or designe	licensing authority for this program is the E programs are required to post a copy of the socation which is accessible to parents, and must the preceding visit and make them available and corrective action plans are also unit at 1-800-852-3345, extension 9025 or 60 tigation visits to licensed programs the department of the licensing counce with licensing rules. Licensing staff are that is respectful and non-leading. However, or to your child being interviewed you must go e, and update annually, a signed dated statchild Care Licensing please visit our website a	statement of findings and st maintain copies of the st maintain copies of the le for parents to review available on-line a 3-271-9025. The artment shall speak with coordinator the children's experienced in working if you do not want your ive the family child care atternent indicating your
	http://www.dhl	ns.state.nh.us/oos/cclu/index.htm	
MEDICAL INFORMATION Any chronic conditions, allergic	es or medications t	hat could be important in case of sudden ill	ness or injury:
lactic tested in a following a	e aller may so er c		
Child's Usual Physician:	um pas sarker i k	Phone number:	21 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
Physician's Address:			
EMERGENCY MEDICAL TR		IODIZATION	
I hereby give permission for the treatment to my child,	on for my child to ment. I also authori- norize licensed heal- cy medical treatme		ency medical facility to inister such treatment as ergency medical facility
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I hereby give permission for the treatment to my child,	on for my child to ment. I also authorize norize licensed heal- cy medical treatme soon as possible rega-	when necessary. In the be transported to a hospital or other emerge ze ambulance/rescue squad attendants to admit the practitioners working in the hospital or ement to my child if warranted. I understand the arding any emergency involving my child. Date	event of a more serious ency medical facility to inister such treatment as ergency medical facility it I will be contacted by

School Kids In Peterborough



Child's Name
Operations / Serious injuries:
July count and the second descriptions are supposed to the second of the
Chronic or recurring illness:
. Their and inside words to a more bindiful, secure which we support
Dietary restrictions:
Learning Difficulties (have an aide during school?)
Physical, Social, Emotional, or Sensory needs:
Activity limitations or special conditions to be watched:
This is a first of the control of th
Allergies to food, drugs, insect stings, plant/pollen, animal or other:
- voltante trop early de la conserva en
I hereby give permission for Conval staff and SKIP staff to share their
knowledge and information about my child.
Parent
Signature: date:

School Kids In Peterborough



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

What three things does your child want us to know about him/her?

What three things do you, the parent, want us to know about your child?

What things does you child not like?

Things I expect from SKIP:

Please list any concerns you may have:

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Doctor's	Universal	Health
form is	riso accept	able.



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Physician must fill out this form for SKIP to administer any prescription.



Use this form to allow us to administer prescription or non-prescription medication to your child. We must have this to dispense any medication, even prescription medication with a doctor's note. If you do not want any medication given to your child while at SKIP, check that box. If you do allow us to give Tylenol, or Advil (Ibuprofen), or Benedryl to your child you may indicate that, and indicate the conditions you are comfortable with. You may say, "call first", or administer per dosage without calling first", etc.

AUTHORIZATION TO ADMINISTER PRESCRIPTION AND NON PRESCRIPTION MEDICATION

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School Kids In Peterborough



	Child's Name
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	Chronic or recurring illness:
	Dietary restrictions:
	Learning Difficulties (have an aide during school?)
	Physical, Social, Emotional, or Sensory needs:
	Activity limitations or special conditions to be watched:
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	Allergies to food, drugs, insect stings, plant/pollen, animal or other:
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	I hereby give permission for Conval staff and SKIP staff to share their knowledge and information about my child.
	Parent Signature: date:
	auto.



Child's Name

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

What three things does your child want us to know about him/her?

What three things do you, the parent, want us to know about your child?

What things does you child not like?

Things I expect from SKIP:

Please list any concerns you may have:



Executive Director Gale F. Hennessy

Deputy Director Fiscal Officer Michael O'Shea

Chief Operating Officer Deborah Gosselin

Outreach Offices in Hillsborough County:

Manchester (03103) 160 Silver Street Tel: (603) 647-4470

Nashua (03060) 134 Allds Street Tel: (603) 889-3440

Greenville (03048) Greenville Falls 56 Main Street Tel: (603) 878-3364

Peterborough (03458) 46 Concord Street Tel: (603) 924-2243

Hillsboro (03244) 63 West Main Street Tel: (603) 464-5835

Outreach Offices in Rockingham County:

Derry (03038) 9 Crystal Avenue, Ste I Tel: (603) 965-3029

Portsmouth (03801) 4 Cutts Street Tel: (603) 431-2911

Raymond (03077) 55 Prescott Road Tel: (603) 895-2303

Salem (03079) Salem Town Hall 33 Geremonty Drive Tel: (603) 893-9172

Seabrook (03874) 638 Lafayette Road Tel: (603) 474-3507

SOUTHERN NEW HAMPSHIRE SERVICES

The Community Action Program for Hillsborough and Rockingham Counties

Mailing Address: PO Box 5040, Manchester, NH 03108 40 Pine Street, Manchester, NH 03103 Telephone: (603) 668-8010 Fax: (603) 645-6734 www.SNHS.org

Dear Parent/Guardians

This letter is intended for parents or guardians of children enrolled in a child care center that offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

- 1. Do I need to fill out a Meal Benefit Form for each of my children in day care? You may complete and submit one <u>CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household only if the children in child care are enrolled in the same center.</u> We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information.
- **2.** Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) or Temporary Assistance for Needy Families (TANF), can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC <u>may</u> be eligible for free meals.
- **3.** Who can get reduced price meals? Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, shown on this application. Children in households participating in WIC <u>may</u> be eligible for reduced price meals.
- 4. May I fill out a form if someone in my household is not a U.S. citizen? Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.
- 5. Who should I include as members of my household? You must include all people in your household (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children who live with you. You also may include foster children who live with you.
- 6. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP or TANF case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

- 7. What if my income is not always the same? List the amount that you normally get. For example, if you normally get \$1000 each month, but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.
- 8. What if I have foster children? Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact Amy Allen, 55 Prescott Road, Raymond, NH 03077, 603-895-2303 x19.
- 9. We are in the military, do we include our housing and supplemental allowances as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.
- 10. (Pricing program only) Will the information I give be verified? Maybe. We may ask you to send written proof to verify the information you submitted on the form. What if I disagree with the decision about the information I complete on this form? You should talk to your sponsoring organization

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call 603-895-2303 x19

Sincerely.

Amy Allen
CACFP Program Specialist
55 Prescott Rd.
Raymond, NH 03077
(603) 895-2303 ext. 19
fax # (603) 895-2330
aallen@rcaction.org

INSTRUCTIONS FOR COMPLETING THE CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Follow these instructions, if your household gets SNAP or TANF

Part 1: List all enrolled children AND household members.

Part 2: List the case number for any household member (including adults) receiving SNAP or TANF benefits.

Part 3: Skp this part. Part 4: Skp this part.

Part 5: Sign the form. The last four digits of a Social Security Number are not necessary.

Part 6: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions

If all children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.

Part 2: Skp this part.

Part 3: Skp this part. Part 4: Skp this part.

Part 5: Sign the form. A Social Security Number is not necessary.

Part 6: Answer this question if you choose to.

If some of he children in the household are foster children.

Part 1: List all household members. For any person, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.

Part 2: If the household does not have a case number, skip this part.

Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [your school, homeless liaison, migrant coordinator]. If not, skip this part.

Part 4: Follow these instructions to report total household income form this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: for each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month or monthly.

- **Box 1** list the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
- Box 2 list the amount each person got from the month from welfare, child support, alimony.

Box 3 - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits.

Box 4 - list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, under *Earnings From* Work, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions

Part 1: List all household members. For any person, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A-Name: List only the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: for each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month or monthly.

- **Box 1** list the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
- Box 2 list the amount each person got from the month from welfare, child support, alimony.

Box 3 - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits.

- Box 4 list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, under *Earnings From* Work, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.
- Part 5: An adult household member must sign the form and list the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.

Part 6: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

	Part 1. All I	Household Members			
Names of ill Enrolled Children (First, Midle Initial, Last)	AND household members	CHECK II LEGAL WELFAR * IF ALL C ARE FOS PART 5	CHECK IF NO INCOME		
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		t 2. Benefits			
If any member of your housel person who receives benefits NAME:	old received SNAP or TANF	cash assistance, pro	3 \ _	number for the	
	Part 3 Ca	ategorical Benefits		- 55-30	
If any childyou are applying fo		Market Company of the	innronriate hov and call vo	ur echool	
homeless laison or migrant co If no category is checked, sl	ordinator. Home			ur scriooi,	
Part 4. Tota	l Household Gross Income	e —You must tell us	how much and how ofte	n .	
A. Name		The state of the s	how often it was received		
List only I household members wit ncome	1. Earnings from work before deductions	Welfare, child support, alimony	Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Incom	
(Example)	(Example)	(Example)	(Example)	TO CATABLE THREE IN	
Jane Smith	\$200/weekly	\$150/twice a month	\$100/monthly	\$/	
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Part 5	Signature and Last Four Digit		Imbor (Adult must sign)	ΙΨ	
An adult household member must of his or her Social Security Nuback of this page.) I certify that all information on this funds based on the information I ginformation, the participant receiving	t sign this form. If Part 3 is cor umber or mark the "I do not h form is true and that all income is ve. I understand that CACFP office	mpleted, the adult signave a Social Security reported. I understand the cials may verify the inform	ning the form must also list Number" box. (See Privacy and the center or day care home mation. I understand that if I pur	Act Statement on the	
Sign here:	awar situte, Minot eon, Jews	Print name:	O malustria independa ha	namichas, a signi	
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City:		State:	Zip Code:	o New Co, 1977 mod	
Last four digits of Social Security			ave a Social Security Numbe		
	Part 6. Participant's ethi		s (optional)	TOTAL TOTAL STATE	
Mark one ethnic identity:	Mark one or more racial identification		ws surre assured		
☐ Hispanic or Latino☐ Not Hispanic or Latino☐	☐ Asian ☐ White ☐ Black or African American	☐ American Indian or ☐ Native Hawaiian or	· Alaska Native · Other Pacific Islander		

FOR OFFICIAL USE ONLY Don't fill out this part.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12
Total Incone: \$ Per: D Week, D Every 2 Weeks, D Twice A Month, D Month, D Year Household size:
Categorica Eligibility: Homeless Runaway
Income Eligibility: ☐ Free ☐ Reduced ☐ Denied ☐ Tier I ☐ Tier II
Reason for Denial:
TemporaryApproval:
Date Withdawn form Program://
Determining Official's Signature: Date:
ConfirmingOfficial's Signature: Date:
Follow-up 0fficial's Signature: Date:

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household size	Yearly				
postura maigin 1 goodle diseas	\$ 20,665				
2	\$ 27,991				
Jeanna Shedray 3 Gasa nos.	\$ 35,317				
4	\$ 42,643				
5	\$ 49,969				
6	\$ 57,295				
7	\$ 64,621				
8	\$ 71,947				
Each additional person:	\$ 7,326				

Privacy Act Statement: 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, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. 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 for the participant or other (FDPIR) identifier 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 if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

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 USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

Read asky fill out whore there Dear Parent/Guardian: 15 am askner.

Child and Adult Care Food Program CHILD AND/OR ADULT ENROLLMENT FORM

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

Mother Phone # Father Phone #	Parent/Guardian Workplaces:	Home Phone #	Mailing Address	Parent/Guardian Names	Please Print					*	采	Full Name of Child / Adult in Family Enrolled in CACFP	2	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(rendendance. Please ensure that this document represents the most current profile of your child(ren)'s enrollment status. Update and certify this document annually.	Sponsoring Organization CACFP Representative Name Patty Carignan, CACFP Coordinator	Sponsoring Organization Name Southern NH Services, Inc. Sponsoring Organization Phone # 603-668-8010 x 6048 Child Care Provider/Business Name School Kids M		Sponsoring Organization Name Southern
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										P		Adult Arrives at Day Care	Time Child/	nt the act	dinator	tox		ດ
												Goes to School	Time	ual time ent prof		Peter borough		
	Cate	4	Parent/Guardian Signature	To the informa	R							Return s from School	Time	of enrolli ile of you		Sugar Sugar		
				To the best of my knowledge a information is correct.		-						Adult Leaves for Home	Time Child/	lment rei ır child(r	Parer		Chec	
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() New enrollment		Effective Date of Form:		For CACFP Representative Use Only Sponsor Signature		≺ z	× z	× z	× z	× z	≺ z	No-School Days (Circle One)	Attendance during	rate arrival and departure times each day of the child(ren) in art status. Update and certify this document annually.	= -	certify that the information recorded below remains true and accurate	One: I certify that the changes noted, initialed and dated below are true and accurate.	Annual Renewals:
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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 (TTV). USDA is an equal opportunity provider and employer.