School Kids In Peterborough

14 Vine Street • Peterborough NH 03458 • 603 924-7050 Phone/Fax

_____New Contract _____Contract Change _____Contract Cancellation

Registration Fee___$45(Child) _____$60(Family*

(_____) Cash (_____) Check#_____

Parent(s) Name:_____

Address:_____

Town/State/Zip:_____

Telephone: (h) _____(w)_____(c)_____

E-mail:_____ ☐ I allow communication between PES and SKIP regarding my child(ren) and transfer of health information and forms.(mandatory)

☐ I would prefer electronic billing at the email above ☐ I prefer paper bill picked up at SKIP

I hereby contract with SKIP Inc. to provide childcare for the listed children on a weekly basis, for the balance of the ConVal School Year on campus learning days.

Child's Name:_____Age:___Grade___Teacher_____Start Date:_____

Date of birth:_____

minimum 3 days/ week each time slot or will be billed at drop-in (emergency) rate.

child one

	Monday	Tuesday	Wednesday	Thursday	Friday	Cost
Mornings						
PM till 6PM						

Weekly Total $_____

Child's Name:_____Age:___Grade:___Teacher:_____Start Date:_____

Date of birth:_____

child two

	Monday	Tuesday	Wednesday	Thursday	Friday	Cost
Mornings						
PM till 6PM						

Weekly Total $_____

By signing this form I claim financial responsibility to pay the weekly total per child on a monthly basis according to the terms on the reverse side of this contract and to abide by the financial policies. Parents are responsible for payment on occasions when SKIP is closed due to inclement weather.
Payment due 1st of month. Late fee ($25.00) applies after 5th of month,& notification of non returnapplies if payment not received by 10th of month.

Signature_____ **Signature**_____

Read and Sign

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 filled out completely and am returning each page below (please ✔ them off)

☐ contract front AND back ☐ Health forms from your health care provider
☐ Emergency contract page front AND back
☐ About your child front AND back
☐ Medication page (Over the counter permission by you, or prescription info from doctor) (front), and photo permission (back)
☐ CACFP food paperwork **(mandatory all 3 pages -this will be give out first week of school)**

School Kids in Peterborough Contract Details-I understand that:

I understand that:	(please check)
Monthly tuition payments are required on the 1st of each month for that month	
A Late Tuition Fee will be assessed if not paid by the 5th of the month of $25.00	
No attendance is allowed if full tuition is not paid prior to 10th of month	
It is a family's responsibility to notify Director if no bill is received by 28th of month for upcoming month	
Contracted services are billed regardless of attendance	
Contract changes require 14 dayss' notice prior to 1st of next month & cost $25.00	
Contracts are accepted for 5 days per month or drop-in rate applies	
SKIP **closes** at 6:00 pm, any child remaining after this time is $1.00 per minute	
Drop-in attendance requires pre-payment and prior notification to Director	
Drop-in charge is $15.00 per morning, and $22.00 per afternoon	
Checks returned by the bank are assessed a $35.00 Bounced Check Fee	
A second check returned by the bank requires cash or money order payment	
Special Contract days are days not billed requiring a separate contract	
You must notify SKIP if you child will not be attending on a contracted day (we are NOT privy to PES Pick-up Patrol) and can be fined for failure to do so.	

I, have read and understand all registration materials.
I, give SKIP staff permission to speak to PES staff about my child regarding behavior, homework, and health

(signature) (date)

School Kids In Peterborough

CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

4702

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:

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 on-line 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.

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:
http://www.dhhs.state.nh.us/oos/cclu/index.htm

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 _____ 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:

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Child's Name_____

Operations / Serious injuries:

Chronic or recurring illness:

Dietary restrictions:

Learning Difficulties (have an aide during school?) * check if Yes. ☐

Does your child have IEP or 504 plan? If so we would like a copy. ☐

Physical, Social, Emotional, or Sensory needs:

Activity limitations or special conditions to be watched:

* important
Allergies to food, drugs, insect stings, plant/pollen, animal or other:

I hereby give permission for Conval staff and SKIP staff to share their knowledge and information about my child, including medical records

Parent
Signature:_____ date:_____

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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:

Read this → PICK option & sign (or)

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.

PRESCRIPTION MEDICATION WILL BE ADMINISTERED IN ACCORDANCE WITH THE PRINTED PRESCRIPTION LABEL, WHICH MUST BE ATTACHED TO THE ORIGINAL PRESCRIPTION CONTAINER.

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.

Either → ☐ I do not authorize any administration or medication to my child while at SKIP.

PARENT'S AUTHORIZATION

I AUTHORIZE CHILD CARE PERSONNEL AT School Kids in Petersburg TO ADMINISTER THE
NAME OF CHILD CARE PROGRAM

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

Non-prescription Medications

NAME OF MEDICATION	DOSAGE	TIMES TO ADMINISTER	BEGINNING DATE	ENDING DATE
tylenol				
Ibuprofen				
benedryl				

☐ Call me first at phone number:

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:

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

CHILD CARE PROGRAM RECORD OF MEDICATION ADMINISTRATION

(TO BE COMPLETED BY CHILD CARE PERSONNEL FOR ALL MEDICATION ADMINISTERED)

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

Note: for prescription medications, a licensed health care practicioner must fill this form out and sign it.

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

Maria Szmaus — 8/2016

SIGNATURE AND POSITION TITLE OF PERSON SUPERVISING ADMINISTRATION/CONTROL OF MEDICATION — DATE SIGNED

Spanish version sent 8/2016

SKIP

14 Vine Street
Peterborough NH 03458

I _____,
Parent Signature

give permission to school Kids in Peterborough to use photographs of my son(s) or daughter(s),

_____

for the purpose of promoting our facility, encouraging volunteers, as well as creating brochures and other promotional materials, or for possible publication in a local newspaper, or on our website and facebook connection page.

☐ I would allow my child's first name to be used.

☐ I prefer no name used for my child.

Maria Szmauz, Director

School **K**ids **I**n **P**eterborough