WAYPOINT
Help Along the Way

Formerly
CHILD AND FAMILY SERVICES

Welcome to TCP!

Here is your Registration Packet with a few tips from your Director:

1. **Please fill out all forms in the Registration Packet.**
2. **If you have any questions, please call: 603-224-9920**
3. **Our annual registration fee of $75 is due on or before starting.**
4. **Once you return your completed forms, please check in with your Director to set up a tour & meet-and-greet with your child (only if you have not had your meet-and-greet already).**
5. **It takes 1-2 weeks to process your paperwork, and you will be getting a start date within that timeframe.**

Payments are accepted as cash, check or on-line (myprocare.com)

Please make checks payable to: Waypoint

Our fall rates are as follows and will begin on September 5, 2023

Daily Rate: $52/day

Weekly Rate: $250/week

Weekly Full-Time with Extended Day: $275/week

Toddler Hours: 8:30-1:00

Preschool-Pre-K Hours: 8:30-3:00 (Extended Day: 3:00-5:00)

😊 We are looking forward to working with you and your child! 😊

Accredited By COA Council on Accreditation
Accredited

CONCORD

toll free (800) 640.6486
office (603) 224.7479
fax (603) 224.7445

103 No. State St.
Concord, NH 03301
waypointnh.org

A Program of Waypoint
27 Burns Avenue
P. O. Box 576
Concord, NH 03301

The Children's Place
and Parent Education Center
A place for children and their families

January 30, 2023

Hello Families,

Welcome to The Children's Place and Parent Education Center. I wanted to take a moment to share my enthusiasm and gratefulness to be here at TCP. It has been an honor and privilege to be working as the Director of TCP for over 2 years, with the most amazing teachers and staff. We all work together to ensure a positive, exciting learning environment for all children who enter the doors at TCP. I am looking forward to getting to know you and your child(ren)! 😊

My name is Kelly Bozetarnik and I have been a teacher for 15 years and working with children for over 20 years. I grew up in New Hampshire and I graduated from UNH with my Master's in Education and my Bachelor's in Psychology. I lived in San Diego, CA for 12 years and met my husband, Josh who was originally from Vermont! We have two children; Owen is 5 and Lily is 3. They both attend our school, and it has been so wonderful to watch them learn and grow alongside their friends here at TCP.

In the past 20 years, I was the Director of two programs, which I loved! I was also a tutor, a reading and math support teacher, and classroom teacher. I have taught Pre-K through 3rd grade, working with students of all abilities and each year having the experience of working with English Learners. I have always felt that children learn best when they are in a positive, encouraging environment where they feel safe enough to participate and join in on the fun!

At TCP, we feel that play-based learning is the key to success! Play-based learning has proven to create well-balanced, inquirers who are compassionate and strong leaders. I have seen so much growth in every child who has attended The Children's Place; it is remarkable! We all enjoy getting to know our students and families, which allows us to create an environment in which they can learn and grow as a whole person. Having a solid educational foundation based on community and kindness is something I was given and will always cherish! This is what we all strive for at TCP. Welcome to our TCP family. 😊

Kelly Bozetarnik

TCP Director

DAILY schedule

8:30-9:00	Welcome - Guided Play
9:00-9:30	Morning Meeting
9:30-9:45	Breakfast
9:45-10:30	Small Group - Teacher Directed Learning Time
10:30-11:30	Recess, Exercise, Stretching, Sensory Play
11:30-12:00	Lunch
12:00-12:15	Small Group Guided Play
12:15-12:30	Story Time
12:30-1:30	Rest/Quiet Time
1:30-2:00	Buddy Read - Sensory Play
2:00-3:00	Snack, Free Play, Dismissal

myprocare®

Dear Parent/Guardian,

The Children's Place is pleased to offer **MyProcare**, a free online portal for you to access account information and easily pay tuition. MyProcare is safe, secure and created with your convenience in mind.

Log in today!

1. Go to MyProcare.com.

2. Enter your email address (the email you have on file with The Children's Place and Parent Education Center) and
choose ***Secure Login***.

3. Enter the confirmation code sent to your email, choose a password, and press ***Submit***.

4. Then you may:
    a. View your child's schedule, time card, immunizations and more.
    b. Use the ***Pay*** button to make a payment with your card.
    c. Access Billing & Tax Statements.

Thank you!

Kelly Bozetarnik, Director
The Children's Place and Parent Education Center

CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

The Children's Place & Parent Educ. Center CCCB-001696

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. 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 _____ 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:

ALL ABOUT

Your Child

Child's Name: _____ **Nickname:** _____

Personality & Interests

Describe your child's personality in 5 words:

1. _____ 2. _____ 3. _____

4. _____ 5. _____

What are your child's interests and hobbies?

_____

_____

_____

Strengths & Challenges in School

What are your child's strengths in school?

_____

_____

What are your child's challenges in school?

_____

_____

ALL ABOUT *Your Child*

continued

Feelings & Goals

How does your child feel about school?

What goals do you have for your child this year?

Supporting Your Child

How can we support your child and family?

Is there anything else we should know?

New Hampshire Early Childhood Health Assessment Record

FOR USE FROM BIRTH THROUGH GRADE 3

To Parent or Guardian: In order to provide the best experience for your child, early childhood providers and school staff must understand your child's health needs. This form requests information from you (Part I) which also will be helpful to the primary health care provider when he or she completes the health evaluation (Part II).

Part I: FAMILY INFORMATION AND HEALTH HISTORY (to be completed by parent or guardian)

Important: *Complete this page BEFORE you give this form to your child's primary care provider.*

Please print

Name of Child/Student (Last, First, Middle)	Birth Date	Sex	Primary Care Provider
Address (Street)		Town and ZIP Code	
Parent/Guardian (Last, First, Middle)	Home Phone Number		Work/Cell Phone Number

Is your child currently enrolled in WIC? Yes / No

Does your child have health insurance? Yes / No*

**If your child does not ha health insurance, talk to yo primary care provider or vi https://nheasy.nh.g*

Please check "Yes" or "No" next to each question below. Use this checklist to talk to your child's primary care provider about your answers.

	Yes	No	
1	☐	☐	Do you have any questions or concerns about your child's health, development, or behavior? *If "Yes," be sure to discuss these with your child's primary care provider. You may also contact NH Watch Me Grow at your community's family resource center (for children < 6 years) or your school district (children 3 and older) for information about free screenings.*
2	☐	☐	Do you have any concerns about your child's eating or sleeping habits?
3	☐	☐	Has your child had a dental exam in the past 6 months?
4	☐	☐	Does your child have any ongoing health problems (such as asthma, diabetes, or seizure disorder)?
5	☐	☐	Does your child have any allergies (to food, medication, insects, latex, etc.)?
6	☐	☐	Does your child require a special diet while in school or other early childhood program?
7	☐	☐	Does your child take any medications (daily or occasionally)?
8	☐	☐	Does your child have any difficulty with his/her vision, hearing, or speech?
9	☐	☐	In the past 12 months, has your child experienced any difficulty with wheezing or coughing?
10	☐	☐	In the past 12 months, have you been concerned about a change in your child's weight?
11	☐	☐	In the past 12 months, have you noticed any change in your child's appetite or thirst?
12	☐	☐	In the past 12 months, have you noticed that your child is urinating more frequently?
13	☐	☐	Has your child ever been hospitalized or had any operations, procedures, or special tests?

Explain any "yes" answers here. Give approximate dates for any hospitalizations, operations, or serious illnesses:

PERMISSION TO EXCHANGE INFORMATION

I, Name of Parent/Guardian, authorize and request my child's primary care provider to exchange information about my child's health and development as pertains to this form with the program/school listed below. The information may be provided by phone, fax, mail, or in person. I understand that the disclosed information will be considered confidential and will be used only for the health and educational benefit of my child and family. Except as needed to comply with federal and state regulations, it will not be re-disclosed to any other person, school, or agency without my consent. I understand that this form will expire in one year unless I choose to cancel my permission in writing before that time.

Name of Program/School Requesting Information

Program/School Mailing Address — Signature of Parent/Guardian — Date

Program/School Telephone Number — Fax Number — Signature of Witness — Date

Endorsed by the NH Department of Health and Human Services; the NH Department of Education; NH Women, Infants & Children Nutrition Program; Head Start; and the NH Pediatric Society

New Hampshire Early Childhood Health Assessment Record

Part II: PHYSICAL EXAMINATION, SCREENING, AND MEDICAL CONDITIONS

To be completed by the child's primary health care provider—must be a licensed physician, nurse practitioner, or physician's assistant.

Name of Child/Student	Date of Assessment	PLEASE ATTACH COPY OF IMMUNIZATION RECORD
Birth Date	Date of Next Scheduled Assessment	

Physical Examination

WT *(must be taken within 60 days for WIC)* lb / kg

HT *(must be taken within 60 days for WIC)* in / cm

HC *(If ≤ 2 years)* in / cm

Body Mass Index (BMI) *(If ≥ 2 years)* ☐

☐ 5–84th % ile ☐ < 5th % ile
☐ 85–94th % ile ☐ ≥ 95th % ile

BP *(If ≥ 3 years)* / ☐ Within normal range ☐ ≥ 95th % ile

Please comment on any findings outside of normal range, including timeframe for re-evaluation, if applicable:

	Normal Yes	Normal No	Follow-Up Indicated
HEENT	☐	☐	☐
Dental/Oral health	☐	☐	☐
Cardiac	☐	☐	☐
Lungs	☐	☐	☐
Abdomen	☐	☐	☐
Back/Extremities	☐	☐	☐
Breasts/Genitalia	☐	☐	☐
Neurologic	☐	☐	☐
Skin	☐	☐	☐

Preventive Screening

HEARING

PLEASE NOTE: Objective hearing screening beginning at age 4 years is REQUIRED for Head Start

Date performed: / / L ☐ Pass ☐ Fail R ☐ Pass ☐ Fail Method: ☐ Audiometry ☐ OAE

Was child referred for rescreen or further evaluation? Y ☐ N ☐ Does child wear a hearing aid? Y ☐ N ☐

VISION

PLEASE NOTE: Objective vision screening beginning at age 3 years is REQUIRED for Head Start

Date performed: / / L 20/ R 20/ Both 20/ Method: ☐ Snellen ☐ Tumbling E ☐ Other

Was child referred for rescreen or further evaluation? Y ☐ N ☐ Does child wear glasses? Y ☐ N ☐

LABS

PLEASE NOTE: Hgb or HCT values at ages 1 and 2 years, and lead levels at ages 1, 2, and 3-6 years are REQUIRED for Head Start

HGB: g/dL HCT: % Date: / /

HGB: g/dL HCT: % Date: / /

Lead: mcg/dL Date: / /

Lead: mcg/dL Date: / /

Lead: mcg/dL Date: / /

Is child at risk for TB? N ☐ Y ☐

If yes, PPD result: POS / NEG Date: / /

DEVELOPMENTAL SCREENING *(e.g., ASQ, ASQ-SE, M-CHAT, PEDS)*

Date of screening: / /

Screening tool(s) used:

Typically developing:	Y	N	Referred
Gross motor	☐	☐	☐
Fine motor	☐	☐	☐
Language/communication	☐	☐	☐
Problem-solving	☐	☐	☐
Social/emotional	☐	☐	☐

Special Needs

Chronic medical conditions/related surgeries?	☐ No ☐ Yes ☐ Special care plan attached*
Medications or treatments?	☐ No ☐ Yes ☐ Special care plan attached*
Allergies/sensitivities?	☐ No ☐ Yes ☐ Special care plan attached*
Behavioral issues/mental health diagnoses?	☐ No ☐ Yes ☐ Special care plan attached*
Limitations to physical activity?	☐ No ☐ Yes ☐ Special care plan attached*
Special equipment needs?	☐ No ☐ Yes ☐ Special care plan attached*
Special dietary requirements?	☐ No ☐ Yes ☐ Special care plan attached*

List special needs/considerations and medications below (other than in attached special care plans). Please attach Special Meals Prescription Form, if applicable.

Name, address, and telephone no. of primary health care provider *(please print or use stamp)*:

Signature of Primary Health Care Provider Date

**Please attach any special care plans or other information*

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

Dear Parent/Guardian:

Your child / 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 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 because it provides nutritious meals and snacks.

Sponsoring Organization Name MVDCS

Sponsoring Organization Phone # 603-224-1632

Child Care Provider/Business Name The Children's Place

Sponsoring Organization CACFP Representative Name _____

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.***

Full Name of Child / Adult in Family Enrolled in CACFP	Date of Birth	Age	Time Child/ Adult Arrives at Day Care	Time Child Goes to School	Time Child Returns from School	Time Child/ Adult Leaves for 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						
	/ /													Y N						
	/ /													Y N						
	/ /													Y N						
	/ /													Y N						
	/ /													Y N						

Please Print

Parent/Guardian/Client Name: _____

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 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. This institution is an equal opportunity provider.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (CHILD CARE/FDCH)

PART 1. ALL HOUSEHOLD MEMBERS

Names of all household members (First, Middle Initial, Last)	Name of each child's school /or indicate "NA" if child is not in school	Place a check in the box below if child is a foster, homeless, migrant, runaway, or Head Start child. If each child attending school is a foster, homeless, runaway, migrant or in Head Start, skip to part 4 to sign this form.					Place a check in the box if NO income
		Foster	Homeless	Migrant	Runaway	Head Start	

PART 2. BENEFITS: If any member of your household receives SNAP or TANF ASSISTANCE, provide the name and case number for the person who receives benefits and skip to part 4. if no one receives these benefits, skip to part 3.

NAME:_____ PROGRAM NAME _____ CASE NUMBER:*(NOT EBT CARD#)* _____

PART 3. TOTAL HOUSEHOLD GROSS INCOME (BEFORE DEDUCTIONS). List all income on the same line as the person who receives it. Check the box for how often it is received. RECORD EACH INCOME ONLY ONCE.

1. Name (list **only** household members with income)	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED																			
	Earnings from work before deductions	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Social Security, SSI, VA, retirement benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All other income (such as Unemployment) benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly
(Example) Jane Smith	$200	X				$150		X			$0					$0				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				

PART 4. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN): An adult household member must sign the application. **If Part 3 is completed, the adult signing the form also must list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Statement on the back of this page.)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____

Last four digits of Social Security Number: ***-**-____ ☐ I do not have a Social Security Number

PART 5. CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

Choose one ethnicity:

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Choose one or more (regardless of ethnicity):

- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ White
- ☐ Native Hawaiian or other Pacific Islander

Your children may qualify for free or reduced price meals if your household income falls at or below the limits on this chart.

FEDERAL ELIGIBILITY INCOME CHART For School Year **2021-2022**

Household size	Yearly	Monthly	Weekly
1	$ 23,828	$1,986	$459
2	32,227	2,686	620
3	40,626	3,386	782
4	49,025	4,086	943
5	57,424	4,786	1,105
6	65,823	5,486	1,266
7	74,222	6,186	1,428
8	82,621	6,886	1,589
Each additional person	+ $8,399	+ $700	+ $162

DO NOT FILL OUT THIS PART. THIS IS FOR SCHOOL USE ONLY.

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

Total Income: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____

Categorical Eligibility: _____ Eligibility: Free____ Reduced____ Denied____ Date Withdrawn: _____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Verifying Official's Signature: _____ Date: _____

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 your child 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 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 if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. 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.

USDA Nondiscrimination Statement

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.

The Children's Place
and Parent Education Center
A place for children and their families

Income Verification Form

We ask that you please complete the following information as detailed as possible. This information will enable The Children's Place to provide our participants the best services available.

Head of Household Name _____

Marital Status: Married _____ Single _____

Race: White/Non-Hispanic _____ African-America/Non-Hispanic _____ Hispanic _____
Asian/Pacific Islander _____ Native America _____ Other: _____

Street Address _____ Mailing if Different _____

City/State/Zip _____ Home Phone _____

Work Phone _____ Cell Phone _____

E-Mail Address _____

Please List All Household Members, Including Head of Household

Name _____ DOB _____ Student Yes/No

Name _____ DOB _____ Student Yes/No

Name _____ DOB _____ Student Yes/No

Name _____ DOB _____ Student Yes/No

Name _____ DOB _____ Student Yes/No

Name _____ DOB _____ Student Yes/No

Name _____ DOB _____ Student Yes/No

Please Detail All Gross Income & Work Hours for All Household Members

Your Wages $_____Weekly____Bi-Weekly____Monthly ____ Weekly Hours_____

Other Wages $_____Weekly____Bi-Weekly____Monthly ____ Weekly Hours_____

Other Wages $_____Weekly____Bi-Weekly____Monthly ____ Weekly Hours_____

Other Wages $_____Weekly____Bi-Weekly____Monthly ____ Weekly Hours_____

What is the household work pattern? Nine to five? Days/Nights? Changing Pattern?

_____

Has anyone recently lost a job? Yes_____ No_____

Does anyone receive benefits?

SSA/SSDI $_____ SSI $_____

VA $_____ Spousal Support $_____

Pension $_____ Unemployment $_____

Child Support $_____ Other $_____

Food Stamps $_____ Fuel Assistance $_____

Do all members in your household have health insurance? Yes_____ No_____

Are any household individuals disabled? Yes_____ No_____

Signature _____ Date _____

Print Name _____

Allergy and Sensitivity Information

Please fill out an Allergy/Sensitivity Information form for your child if he/she has a food allergy or sensitivity. This will be added to their files and also put in a visual place for our teachers and staff to ensure that all children's and family's needs are being met.

If your child has an:

ALLERGY: We will *need* a note from your child's Primary Care Physician as soon as possible stating to what foods that your child is allergic. A note from your child's PCP is required. In the comments area, please state if your child has an Epi-Pen or other forms of medical treatment. Briefly explain the nature of the reactions to expect in the event that an allergic reaction may occur. This can be hives, swollen eyes, rashes etc.

INTOLERANCE/SENSITIVITES: We understand that all children are different, but an intolerance/ sensitivity is not the same as an allergy. If you would rather your child have a *milk alternative* such as almond milk, lactaid, or soy milk etc., please write in the comments area and specify what you want your child to have or NOT have. Example: If you would rather your child have water instead of milk, please state it clearly. This will act as the "note from a parent" which is required.

PERSONAL PREFERENCE: A personal preference would be if you and your family choose to be vegetarians, vegan etc. but that in the event that your child consumes a product such as milk, there won't be an immediate reaction causing medical attention. Please state in the comments area if you will be providing snacks/meals for your children. This will act as the "Note from a parent" which is required.

Childs Name: _____ **Date of Birth:** _____

My Child has an: Allergy_____ **Intolerance/Sensitivity**_____ **Personal Preference** _____

The allergy/sensitivity is to: _____

This is what happens and what to look for: _____

This is what needs to be done: _____

Comments: _____

_____

For all allergies we *must* have physician's documentation on file _____

Parent's Initials Please

Today's Date: _____ **Signature:** _____

Sunscreen/Bug Spray Release

I, _____, give permission for The Children's Place and Parent Education Center to apply sunscreen, bug spray to my child, _____.

Parent/Guardian signature: _____

I do not give permission: _____

Date: _____

Diaper Rash Cream

I, _____, give permission for The Children's Place and Parent Education Center to apply diaper rash cream that I provide for my child, _____.

Parent/Guardian signature: _____

I do not give permission: _____

Date: _____

Photo Release

I, _____, Parent/Guardian of _____ hereby authorize and consent to the use of his/her visual image by The Children's Place and Parent Education Center for appropriate purposes, including but not limited to: still photography, electronic and print publications and websites.

Parent/Guardian signature: _____

I do not give permission: _____

Date: _____