First Start

Children's Center

Let me be the first to welcome you to First Start Children's Center!

Our center is fully licensed by the NH Department of Health and Human Services, Bureau of Child Care Licensing and is a Licensed Plus provider through the NH Child Development Bureau. First Start is a participant in the NH Child Care and Adult Food Program sponsored by the NH Department of Education. Through the generous support of the United Way and the New Hampshire State Scholarship Program, we are able to help low and moderate income families access scholarship assistance enabling them to receive quality care at an affordable tuition.

First Start has programs for infants, toddlers, preschoolers, as well as an afterschool program and a school-age summer camp program. Our center provides a warm, nurturing and safe atmosphere where self-concepts are enhanced, independence encouraged and individuality is respected. We are able to make reasonable accommodations to include each child by working closely with families and welcoming support services from outside agencies.

Our philosophy is based on the premise that children learn most effectively through structured play and social experiences. We believe that child centered and teacher directed curriculum work best when carefully integrated into the daily routine. Each program's curriculum is designed to offer children many activities carefully planned to serve their developmental needs. Daily schedules consist of a combination of structured and free-time activities centered on a particular theme or concept and designed to promote gross and fine motor skills, problem solving, communication and language development, as well as social and self-help skills. Parents are our partners and are welcome at the center any time during program hours.

Please feel free to contact me at 228 - 1341 ext. 4203 during the hours of 9:00 am and 4:00 pm to answer any questions you may have.

Welcome,

Sally Wood
Director
First Start Children's Center

CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

First Start Children's Center **CCCB-00993**

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:

PRE-SCHOOL INTAKE FORM

Child's Name _____ Birthdate _____

Parents _____ Home Phone _____

_____ Address_____

Who will bring child? _____ Pick up child? _____

Names of people who share the home _____

If father/mother does not live with child, does child see him/her

regularly? _____, frequently? _____, seldom? _____, never? _____

Who normally cares for child when mother/father must be away? _____

Other school or group experiences? _____

How do you expect your child to react to their enrollment in our center? _____

_____

What fears might your child have? _____

How does your child react to these fears? _____

Any frightening experiences we should know about? _____

_____

Any allergies to food, or other allergies?_____ Has your child ever been stung? _____

Reaction or symptoms to look for: _____

Child's special interests _____

Favorite TV shows _____

Favorite books or stories _____

Please describe any other issues you think we should know about your child_____

_____

Preferred discipline _____

Does it seem to work? _____

Does your child often play with other children? _____

What do you feel is your child's greatest need at this time? _____

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 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 have health insurance, call 1–877–464–2447 (NH Healthy Kids)*

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

	Yes	No	
1	☐	☐	Do you have any questions or concerns about your child's health, development, or behavior?
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 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 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.

First Start Children's Center
Name of Program/School Requesting Information

17 Knight St Concord NH 03301
Program/School Mailing Address

Signature of Parent/Guardian

Date

228-1341 228-3852
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

May 2011

New Hampshire Early Childhood Health Assessment Record

Part II: PHYSICAL EXAMINATION, SCREENING, AND MEDICAL CONDITIONS

(To be completed by the child's primary care provider)

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	Body Mass Index (BMI) *(if ≥ 2 years)* ☐
HT	*(must be taken within 60 days for WIC)*	in / cm	☐ *5–84th % ile* ☐ *< 5th % ile* ☐ *85–94th % ile* ☐ *≥ 95th % ile*
HC	*(if ≤ 2 years)*	in / cm	BP *(if ≥ 3 years)* / ☐ Within normal range ☐ ≥ 95th % ile

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

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

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

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

Screening tool(s) used:

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 health care provider *(please print or use stamp):*

Signature of Health Care Provider Date

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

Please complete the following Health History so that we may be aware of any of his/her special Health needs. The information will remain confidential.

HEALTH HISTORY

CHILD'S NAME _____ DOB_____

CHILD'S PHYSICIAN_____ PHONE#_____

Date of last physical: _____

PRENATAL AND BIRTH HISTORY

Were there any problems during your pregnancy or delivery? Yes___ No_____
If yes, what? (such as bleeding, spotting, medications taken, special tests, serious accidents or illness, bit1h difficulties)

_____

_____

Child's Birth Weight_____ Was your child full term? _____

Number of months of gestation? _____

Did your child have any difficulties right after birth? (such as jaundice, problem breathing, or anything requiring special treatment) .

_____

_____

MEDICATION AND ALLERGIES

Does your child take any medication?

Drug Name:	How Often:	Doctor Prescribing:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Will your child need it during Daycare? Yes____ No____

Has your child ever had:	Yes	No	How does your child react?
Food Allergies	_____	_____	_____
Eczema or Hives	_____	_____	_____
Wheezing or Asthma	_____	_____	_____
Allergies or Reactions to Medications	_____	_____	_____
Allergies to pollen/dust/or other substance	_____	_____	_____
Tend to have a constant cold or runny nose	_____	_____	_____

ILLNESS HISTORY

Has Your Child Had or Do They Have	Yes	No	Date	Comments
Polio				
Measles				
Mumps				
Chicken Pox				
German Measles				
Whooping Cough				
Rheumatic Fever				
Meningitis				
Pneumonia				
Scarlet Fever				
3 Attacks of Ear Trouble				
More Than 3 Colds With Fever a Year				
More Than 3 Throat Infections a Year				
Seizures, Fits, Convulsions or Spells				
Tonsillectomy				
Broken Bones				
Serious Accidents				
Any Hospitalization				
Any Hearing Problems				
Any Vision Problems				
Any Problems Sleeping				
Any Trouble With Urinating/Urinary Inf.				
Frequent Bed Wetting Now				
Exposure to TB or Person With Chronic Cough				
Any Known Handicapping Conditions				
Heart Disease/Murmur				
Liver Disease				
Kidney Disease				
Diabetes				
Myringotomy Tubes (ears)				
Eaten Non-Food Items				
Problem Eating				
Physical Disability				
Orthopedic Problems				
Other Serious Illness				

How does your child react to an elevated temperature? _____

DEVELOPMENTAL HISTORY

Do you have any questions or concerns about your child's development in the following areas?

	Fast	Ave.	Slow	Comments
Compared with Brothers, Sisters and other children, Has your child been particularly				
Sitting Unsupported				
Walking – Running - Climbing				
Talking				
Playing with toys – Coloring – Drawing				
Understanding what's said to him/her				
Getting along with other children				
Toilet Training				

BEHAVIOR

Does your child exhibit any of the following?	Yes	No	Comments
Clumsiness			
Nail Biting			
Irritability			
Speech Problems			
Tantrums			
Thumb Sucking			
Breath Holding			
Nightmares			
Refusal to Mind			
Overactive			
Jealousy			
Bad Temper			
Acting Difficult or Different			

PERSON COMPLETING THIS FORM:

Signature _____ Date_____

Relationship _____

PROCEDURES FOR ADMINISTERING MEDICATION

The New Hampshire Bureau of Child Care Licensing under He-C 4002.18 requires that the Athorization to Administer Prescription and Non-prescription Medication form be completed prior to administration of any medication. All medications must be in the original container and cannot be administered beyond the expiration date.

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 manufacturers' printed instruction 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.

Please be sure to give all medications directly to your child's teacher so they can store them safely out of reach of children and/or refrigerate as required. If you have any questions, check with your child's teacher.

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.

PARENT'S AUTHORIZATION

I AUTHORIZE CHILD CARE PERSONNEL AT First Start Children's Center TO ADMINISTER THE
NAME OF CHILD CARE PROGRAM

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

NAME OF MEDICATION	DOSAGE	TIMES TO ADMINISTER	BEGINNING DATE	ENDING DATE
Acetaminophen				
Ibuprofen				

____

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 INSTRUCTIONA WERE:

- □ **REVIEWED AND APPROVED BY THE ABOVE NAMED LICENSED HEALTH PRATITIONER**
- □ **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

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

____ ______________

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

AUTHORIZATION TO ADMINISTER TOPICAL TREATMENTS

Child's Name: _____ Date of Birth: _____

Parent	Provided	Daycare	Provided
_____	Diaper Cream	_____	Petroleum Jelly (Vaseline)
_____	Sunscreen	_____	First Aid Ointment (Bacitracin)
_____	Insect Repellent	_____	Baby Wipes
_____	Lotion		
_____	Lip Balm		

I authorize childcare personnel at First Start to administer the items checked above. I understand that it is my responsibility to apply the sunscreen and insect repellent prior to my child's arrival at the center and that I am required to keep a supply of diaper cream, sunscreen and insect repellent available for my child at the center.

_____ _____

Parent/Guardian Signature Date

First Start Children's Center
17 Knight Street
Concord, NH 03301

Pre-School Permission Form

Please sign and date where indicated.

I give permission for my child _____
(Child's Name)
to participate in the following activities as scheduled by the teachers:

Garrison Park

Go to Garrison Park and to use the park playground equipment.

Neighborhood Walks

Take walks in the following low traffic areas: Knight St. and Hutchins St. (with sidewalks) and Garrison St., Lake St., and Quaker St. (without sidewalks).

_____ _____

(Date) (Parent's Signature)

Photograph Release Form

There are many occasions here at First Start Children's Center that we, the staff, would like to capture in pictures or videos while your child is at work or play.

Please indicate where your child's photos or videos may be used by checking all boxes that apply. Then sign and date below.

- ☐ Classroom and Project Displays
- ☐ Memory Books
- ☐ Agency Publications
- ☐ Agency Website
- ☐ Special Events at the Center with outside organizations who may use photos (i.e. St. Paul's)

I authorize First Start Children's Center to photograph or video my child _____.

Parent Signature: _____ Date: _____

Dear Parent:
To insure your child's comfort while at First Start, please provide the items listed under extra clothing and. Classroom teachers will let you know when to bring in seasonal items. Please be sure to label all items.

Extra Clothing:

* Long Pants
* Shorts
* Underpants (Toddlers-Rainbows)
* Socks
* Short Sleeved Shirts
* Long Sleeved shirts
* Onesies (Infants)
* Extra Shoes

Seasonal:

* Sun hats
* 4-6 hour Waterproof Sunscreen
* Bathing Suit
* Towels
* Swimmies (Minis & Toddlers)
* Waterproof Footwear
* Ski Pants (Minis-Rainbows)
* Boots (Minis-Rainbows)
* Mittens & Hat (Minis-Rainbows)

Miscellaneous:

* Fever/Pain Reliever
* Inhaler or EpiPens if needed
* Diaper Ointment (Infant-Toddlers)
* Comfort Items for Nap

SECOND START

FIRST START CHILDREN'S CENTER

2017-2018 CALENDAR

	M	T	W	TH	F		M	T	W	TH	F
JULY	3	**X**	5	6	7	JANUARY	**X**	2	3	4	5
	10	11	12	13	14		8	9	10	11	12
	17	18	19	20	21		**X**	16	17	18	19
	24	25	26	27	28		22	23	24	25	26
	31						29	30	31		
AUGUST		1	2	3	4	FEBRUARY				1	2
	7	8	9	10	11		5	6	7	8	9
	14	15	16	17	18		12	13	14	15	16
	21	22	23	24	25		**X**	20	21	22	23
	28	29	30	31			26	27	28		
SEPTEMBER					1	MARCH				1	2
	X	5	6	7	8		5	6	7	8	9
	11	12	13	14	15		12	13	14	15	16
	18	19	20	21	22		19	20	21	22	23
	25	26	27	28	29		26	27	28	29	30
OCTOBER	2	3	4	5	6	APRIL	2	3	4	5	6
	X	10	11	12	13		9	10	11	12	13
	16	17	18	19	20		16	17	18	19	20
	23	24	25	26	27		23	24	25	26	27
	30	31					30				
NOVEMBER			1	2	3	MAY		1	2	3	4
	6	7	8	9	**X**		7	8	9	10	11
	13	14	15	16	17		14	15	16	17	18
	20	21	22	**X**	**X**		21	22	23	24	25
	27	28	29	30			**X**	29	30	31	
DECEMBER					1	JUNE					1
	4	5	6	7	8		4	5	6	7	8
	11	12	13	14	15		11	12	13	14	15
	18	19	20	21	22		18	19	20	21	22
	X	**X**	**X**	**X**	**X**		25	26	27	28	29

We are closed for the following days:

July 4	--	Independence Day
September 4	--	Labor Day
October 9	--	Columbus Day
November 10	--	Veteran's Day (observing)
November 23, 24	--	Thanksgiving Break
Dec. 25 – Dec. 29	--	Winter Break
January 1	--	New Year's Day
January 15	--	Martin Luther King Day
February 19	--	Presidents' Day
May 28	--	Memorial Day

First Start Children's Center
Email Address Registration Form

Child's Name _____

Child's Name _____

Child's Name _____

Child's Name _____

Mother's Name _____

Mother's Email Address _____

Father's Name _____

Father's Email Address _____

I understand that I am sharing my email address to receive routine notices such as the weekly menu, monthly newsletters and calendars from First Start Children's Center. First Start Children's Center will hold this information confidential and not share with outside parties.

_____ _____
Signature Date

I choose not to share my email address and will continue receiving the routine notices such as the monthly newsletters and calendars as a hard copy in my child's mailbox.

_____ _____
Signature Date

Dear Day Care Parent:

Your authorization is required to process the electronic transfer for day care tuition payment. To activate this process, please take the time to read the guidelines, complete the enclosed authorization, and attach a voided check from your account as shown on the form. Completed forms should be returned to the Day Care Office.

Please remember that the following conditions will apply to this authorization:

- The amount that will be debited from your account is the weekly amount shown on your most recent childcare tuition agreement.

- Signed tuition agreements must accompany this authorization. If you have not already completed and returned your recent tuition agreement, please see the day care office.

The electronic debit will be will be sent to your bank each Monday morning for that week's tuition. It is scheduled to be deducted from your account on Tuesday. Please note that this date may vary depending upon the communication between our bank and your bank. Also, if there is a holiday on Monday, this debit request is sent to your bank Tuesday morning and is deducted from your account on Wednesday.

- Any and all tuition changes require a new tuition agreement. They are available in the Day Care Office.

- Any requests to terminate or change this authorization must be submitted in writing to the Business Office. This written authorization must be received **no later than Wednesday**. Changes will become effective the following Monday.

- Electronic debit will be for tuition only. Additional charges, i.e. extra days, late fees and/or insufficient fund charges will appear on your monthly statement and are due as of the date of that statement.

- If we are unable to electronically debit your account you will be charged a $10.00 fee per transaction.

- All NSF returns (electronic or paper checks) will be charged a $10 fee.

If you have any questions, please check with the Business Office. For tuition agreements, please see Sally.

Sincerely,

Dot Fournier

Dot Fournier
Business Office

Electronic Funds Transfer Authorization Agreement

Daycare Account #

_____

I hereby authorize Second Start to initiate debit entries and to also, initiate, if necessary, credit entries and make adjustments for any credit entry in error to my (our) account indicated below. This authorization is to remain in full force and effect until Second Start has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Second Start a reasonable opportunity to act on it. These entries are for childcare for _____.

(Child's Name)

Depository Financial Institution Information

Name _____

Address _____

City _____ State _____ Zip _____

Account Information

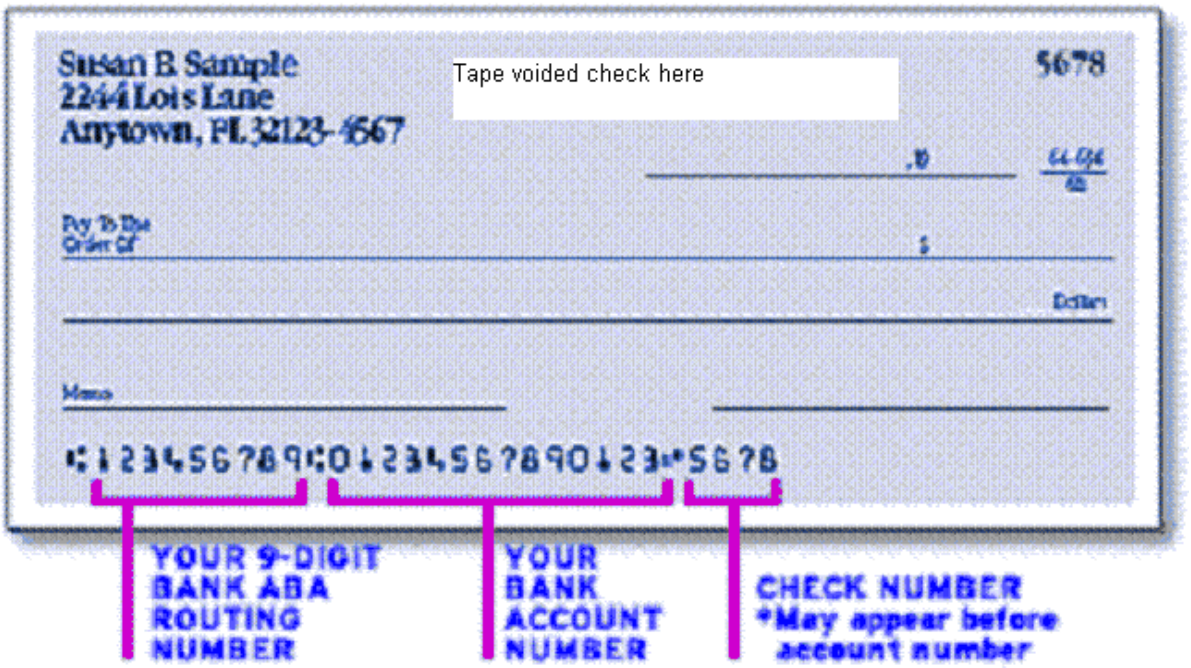
Bank Name _____

9 digit routing number _____

Bank Account number _____

Checking _____ Savings_____

Customer Signature *(required)* _____ Date _____



Change/Revocation

_____ **Change** - change financial institution and account number

_____ **Change** - stop direct deposit program

Signature _____ Date _____

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:	*Choose one or more (regardless of ethnicity):*		
❑ Hispanic/Latino	❑ Asian	❑ American Indian or Alaska Native	❑ Black or African American
❑ Not Hispanic/Latino	❑ 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 **2017-2018**

Household size	Yearly	Monthly	Weekly
1	$22,311	$ 1,860	$ 430
2	30,044	2,504	578
3	37,777	3,149	727
4	45,510	3,793	876

Household size	Yearly	Monthly	Weekly
5	$53,243	$4,437	$ 1,024
6	60,976	5,082	1,173
7	68,709	5,726	1,322
8	76,442	6,371	1,471
Each additional person	$ 7,733	$ 645	$ 149

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.

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: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. *This institution is an equal opportunity provider.*

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_____

Sponsoring Organization Phone #_____

Child Care Provider/Business Name _____

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.