

# 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:
<b>Special Instructions for reaching parent/guardian:</b>	

**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:



AUTHORIZATION TO ADMINISTER TOPICAL TREATMENTS

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

<b>Parent</b>	<b>Provided</b>	<b>Daycare</b>	<b>Provided</b>
_____	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

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

**Infant Walk Permission Form**

The infants go out daily, weather permitting.

We usually walk in the surrounding neighborhood. The children are in seats in our Bye Bye Buggy, with proper seat restraints to ensure a safe ride. We also ensure appropriate staff ratios (4 infants: 1 adult) accompany them.

We travel in areas with sidewalks (Knight St., Hutchins St.) and without sidewalks (Garrison St., Lake St. and Quaker St.) This are low traffic areas and when we walk at the roadside we use proper caution.

At other times, we utilize the Garrison Park Area, adjacent to our building and playground.

I give permission for my child \_\_\_\_\_ to go on daily walks as outlined above.

\_\_\_\_\_  
(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: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_





PART 5. CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)			
<i>Choose one ethnicity:</i>		<i>Choose one or more (regardless of ethnicity):</i>	
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> White	<input type="checkbox"/> 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 <b>2017-2018</b>							
Household size	Yearly	Monthly	Weekly	Household size	Yearly	Monthly	Weekly
1	\$22,311	\$ 1,860	\$ 430	5	\$53,243	\$4,437	\$ 1,024
2	30,044	2,504	578	6	60,976	5,082	1,173
3	37,777	3,149	727	7	68,709	5,726	1,322
4	45,510	3,793	876	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: <input type="checkbox"/> Week, <input type="checkbox"/> Every 2 Weeks, <input type="checkbox"/> Twice A Month, <input type="checkbox"/> Month, <input type="checkbox"/> 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, audiotope, 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](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](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](mailto: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.

**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: \_\_\_\_\_

Sponsoring Organization Name \_\_\_\_\_  
 Sponsoring Organization Phone # \_\_\_\_\_  
 Child Care Provider/Business Name \_\_\_\_\_  
 Sponsoring Organization CACFP Representative Name \_\_\_\_\_

**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 Sn	PM Sn	Su	BT Sn					
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Parent/Guardian/Client Name: \_\_\_\_\_

*To the best of my knowledge all of the above information is correct.*

Mailing Address \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Home Phone # \_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian Workplaces: \_\_\_\_\_

Mother Phone # \_\_\_\_\_ Father Phone # \_\_\_\_\_

**For CACFP Representative Use Only**  
 Sponsor Signature \_\_\_\_\_

Effective Date of Form: \_\_\_\_\_  
 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.