

**WOLFEBORO AREA CHILDREN'S CENTER
180 SOUTH MAIN STREET
WOLFEBORO, NEW HAMPSHIRE 03894**

PARENT CONTRACT

1. I have read and understand all the terms and conditions outlined to me in the *Parent Handbook* and the *Health and Safety Policy*.
2. I understand that I am now a member of the Wolfeboro Area Children's Center, Inc. with all the rights and responsibilities involved.
3. I understand that my participation in the activities of the WACC are essential to maintain the quality of the programs for my child, that I am expected to participate in Fund Raising, building work parties and other activities for the benefit of the Center, and that I may be asked to serve on Board / Parent Committees.
4. I am aware that the Annual Meeting of the Corporation takes place on the fourth (4th) Monday of the month of September, when the election of the representative Board of Directors takes place.
5. I am also aware that the Board of Directors meets on the fourth (4th) Monday of the month from September through June, excluding December, to decide all policies of the WACC. Corporate members are welcome at any meeting and are encouraged to serve on committees to participate in the decision making process of the Corporation.

AGREED ENROLLMENT

1. I am enrolling my child / ren for the following days and time:

Child's Name	Days	Times

	Daily Rate	Weekly Rate	Hourly Rate
Child 1			
Child 2			
Child 3			
Total weekly before credits			
Credit type			
Credit type			
Credit type			

Membership fee: _____ Paid: _____

Renewal date: _____

Parent / Guardian

Date

Wolfeboro Area Children's Center
Executive Director

Date

WOLFEBORO AREA CHILDREN'S CENTER

PAYMENT POLICY

- At the time of enrollment, parents will be notified of their weekly charge. Weekly bills are not issued.
- Payment is due on the first day of attendance every week.
- We accept payment by cash, credit card, or automatic debit monthly from your checking account. (Please request an authorization form for credit/debit payments.)
- Payment may be given to the Receptionist or dropped in the locked mailbox outside the front office.
- Biweekly or monthly payments are accepted, but must be made at the beginning or the middle of the period.
- If payment is not received by noon on Friday for services provided that week, a late fee in the amount of 10% of the balance, up to a \$10.00 maximum, will be charged.
- Parents who wish to “buy time” may charge the overdue amount to their credit card.
- **We will not be able to provide childcare the following week until the account is cleared.**

I have read and understood the terms of the Children's Center's payment policy.

Print Name: _____

Signature: _____

Date: _____

WOLFEBORO AREA CHILDREN'S CENTER

CREDIT CARD AUTHORIZATION AGREEMENT

Thank you for your interest in paying your Children's Center bill with your credit card.

We hope that this convenient method of paying your bill is of benefit to you. However, if you decide that this method of payment is not, you may cancel in writing at any time.

I hereby authorize the Wolfeboro Area Children's Center to charge my credit card account listed below to pay my Children's Center bill.

- Please deduct my overdue charges on Monday when I have not paid for services provided the previous week so that my child's enrollment will not be disrupted.
- Please deduct the amount of my monthly charges on or about the 15th of every month.

Account Name	
Name on Credit Card	
Credit Card Type	
Credit Card Number	
Credit Card Expiration Date	

Cardholder Signature

Date

WOLFEBORO AREA CHILDREN'S CENTER

WOLFEBORO AREA CHILDREN'S CENTER

PARENT AGREEMENT

I consent to the enrollment of my child (ren):

with the Wolfeboro Area Children's center, and agree that the Center shall not be responsible in case of sickness or injury of this child (ren) while in the attendance of a Center facility or in transit to and from the facility with the expectation that the Center will take all necessary precautions for his/her safety and well being.

- o I give my consent for my child (ren) to take part in field trips or excursions under proper supervision (Brewster Beach, Albee Beach, Cate Park, Foss Field, the library, downtown and other Wolfeboro sites).
- o I give my consent to the Wolfeboro Area Children's Center to use for publicity or publication purposes any photos taken by the Wolfeboro Area Children's Center in which my child appears.
- o I give consent to the Kingswood Regional High School students who participate in the vocational school's child care program to use for educational or publicity purposes any film or photographs taken by the students.
- o I understand that the Wolfeboro Area Children's Center reduces staff, by one less staff person in a classroom than required at other times, during naptime for children ages 24 months through 5 years old according to NH Licensing Rules (He-C 4002.23 (i) through (l)).

My child(ren) ___ is ___ is not covered by health insurance. If yes, check one:

- ___ Medicaid or NH Healthy Kids
- ___ Private health insurance- Company

name(s): _____

PARENT SIGNATURE DATE

Updated: _____ Initials: _____ Updated: _____ Initials: _____

Updated: _____ Initials: _____ Updated: _____ Initials: _____

TO PARENT/GUARDIAN: This form **MUST** be updated annually, or whenever the information changes. This form can be updated by completing a new form or by correcting, re-dating and initialing this form.

CHILD HEALTH FORM

To Be Completed by Parent or Guardian:

_____ / _____ / _____
 LAST NAME FIRST NAME MI DOB: M F

CHILD'S ADDRESS

We/I _____ give permission to obtain or release necessary information on the above child.

Please return to: **Wolfeboro Area Children's Center Fax: 569-5733**

HISTORY: To Be Completed by Physician (This information will be held confidential and will be used only for the benefit of this child).

- A. Prenatal, perinatal and postural development. Any significant findings that could influence this child's adaptations to a child care setting (i.e. physical handicap, sensory loss, developmental irregularities)?
- B. Any chronic illness that may require medication, particularly observations or precautions in a child care setting (e.g. recurrent ear infections, seizure disorder, allergies)?
- C. Any hospitalizations, operations, or special tests of which a child care provider should be aware?
- D. Pertinent family, social or health characteristics?

IMMUNIZATIONS FOR CHILD CARE AGENCY ATTENDANCE

You may substitute a copy of your own immunization record

VACCINE	DATE	DATE	DATE	DATE	DATE	DATE
DTP/DTaP						
HIB						
DTP-HIB						
Td						
OPV or IPV						
MMR						
HEP-B						
Varicella (rec)						
Other						

Communicable Disease History

Recommended Screening & Testing of Attendees

Disease	Date of Diagnosis	Laboratory confirmation	Physician		Date	Method	Result
				TB (for high risk children only)			
				Vision			
				Hearing			
				Speech			
				HIB/HCT			
				Urine			
				Lead			

HEALTH ASSESSMENT

PHYSICAL EXAM:

LENGTH/HEIGHT ____ IN/CM %ILE ____	WEIGHT ____ LB/KG %ILE ____	HEAD CIRCUMFERENCE ____ IN/CM %ILE ____	BLOOD PRESSURE ____ / ____
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CHECK EACH LINE	NORMAL	ABNORMAL	NEEDS FOLLOW UP	NOT EXAMINED	CHECK EACH LINE	NORMAL	ABNORMAL	NEEDS FOLLOW UP	NOT EXAMINED
Skin / Scalp					Skin / Scalp				
Nutrition					Nutrition				
Neurology & Muscular					Neurology & Muscular				
Orthopedic & Spine					Orthopedic & Spine				
Eye					Eye				
Ears					Ears				
Speech					Speech				

Temperament: ____ easy going ____ average ____ difficult

COMMENTS:

Assessment of Physical Development:

A. Estimate of level of maturation:

- a) Infancy (0-2 years) Early: ____ Mid: ____ Late: ____
- b) Mid-Preschool (2-4 years) Early: ____ Mid: ____ Late: ____
- c) Preschool (4 years) Early: ____ Mid: ____ Late: ____
- d) School-age (6-10 years) Early: ____ Mid: ____ Late: ____
- e) Adolescent (11-18 years) Early: ____ Mid: ____ Late: ____

B. Estimate of functional capacity:

	Delayed for Development Phase	Consistent with Development Phase	Advanced for Development Phase	Comments
Gross Motor:				
Fine Motor:				
Language Skills:				
Social Skills:				
Emotional				

Print Physician's Name: _____ Date of Exam: _____

Physician's Signature: _____ Date of next scheduled exam: _____

WOLFEBORO AREA CHILDREN'S CENTER

ALLERGY / BENADRYL FORM

Child's Name: _____ (Please complete a separate form for each child.)

My child has an allergy to the following: **

FOOD

REACTION

MEDICATIONS

REACTION

ENVIRONMENT

REACTION

OTHER

REACTION

**If your child has had a severe allergic reaction that has needed medical intervention including but not limited to use of an inhaler or EpiPen, please request an Emergency Action Plan form in addition to this one.

Permission to Administer Benadryl

The Children's Center programs serve very young children, many of whom have not had exposure to potential allergens in their environments. In the event that a child exhibits signs of a severe allergic reaction such as wheezing, croupy cough, hoarseness, difficulty breathing or swallowing, chest or throat tightness, drooling, slurred speech, confusion, weakness and fainting, rash, hives, itching, and facial swelling, we will:

- Administer an age and weight appropriate dose of Benadryl;
- Call 911;
- Contact parent or other designated emergency contact;
- And observe the child closely for changes until the emergency medical team arrives.

I, _____, give permission to the personnel of the Wolfeboro Area Children's Center to administer an age and weight appropriate dose of Benadryl should my child, _____, exhibit signs of a severe allergic reaction such as wheezing, croupy cough, hoarseness, difficulty breathing or swallowing, chest or throat tightness, drooling, slurred speech, confusion, weakness and fainting, rash, hives, itching, and facial swelling.

SIGNATURE PARENT/GUARDIAN

DATE

CHILDCARE REGISTRATION AND EMERGENCY INFO

Wolfeboro Area Children's Center, Inc.

License # 0977

TO THE PARENT OR GUARDIAN: This form must be completed for each of your children who will be enrolled in the program, and must be updated whenever information changes. You must also either complete a new form annually, or update this form annually by following the instructions at the bottom of the reverse side of this form.

DATE OF ENROLLMENT: _____

Child's name: _____ DOB: _____

Child's name: _____ DOB: _____

INFORMATION OF PARENT OR GUARDIAN/S LEGALLY RESPONSIBLE FOR CHILD

Name: _____ Name: _____

Address: _____ Address: _____

Home Phone: _____ Hours: _____ Home Phone: _____ Hours: _____

E-mail address: _____ E-mail address: _____

INDICATE WHERE PARENT/GUARDIAN CAN BE REACHED WHILE CHILD IS IN CARE. INCLUDE NAME OF BUSINESS IF APPLICABLE, ADDRESS AND PHONE NUMBER, PLUS ANY SPECIAL INSTRUCTIONS, I.E. PAGER, CELL PHONE, ETC.

Name: _____ Name: _____

Business Name: _____ Business Name: _____

Address: _____ Address: _____

Phone: _____ Hours: _____ Phone: _____ Hours: _____

E-mail address: _____ E-mail address: _____

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 or injured and you were not accessible, or if you experienced a sudden illness or were injured between work and picking up your child.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

NON-EMERGENCY ALTERNATE PICK UP PERSONS (S) I, _____
Parent/Guardian Signature Date

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: _____ Phone: _____

NOTE TO PARENTS:

The licensing authority for this program is the Bureau of Child Care Licensing. 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 <http://childcaresearch.dhhs.nh.gov> or by calling the bureau at 603 271-4624 or 1 800 852-3345, extension 4624.

During licensing, monitoring, and complaint investigation visits to licensed programs the department shall speak with children regarding the care they receive at the program if in the judgment of the licensing specialist the children's response would be valuable in determining compliance with licensing rules. Licensing staff are experienced in working with children and trained to interview in a manner that is respectful and non-leading. However, if you do not want your child interviewed, or if you wish to be informed prior to your child being interviewed you must give the family child care provided, center director or designee, and update annually, a signed statement indicating your preference.

The well being of children is our concern. BCCL staff recognize that interviewing young children is a delicate responsibility. Therefore, the licensing (specialists) will make every attempt to help any child they interview feel comfortable by being gentle, reassuring, sensitive and casual. They will spend time with the child and will take into account the child's level of maturity and willingness to talk to us.

The licensing specialist(s) ask the teachers to introduce them to the children and briefly explain the licensing specialist(s) role. The licensing specialist(s) ask open-minded questions. They randomly select which children they will speak with, and invite those children to tell the licensing specialist(s) about their childcare program/school, however, no child is ever forced to speak with a licensing specialist. If a child appears uncomfortable about speaking or declines the licensing specialist(s) invitation, they select another child. No child is ever pressured to speak with a licensing specialist. Generally the children enjoy telling an interested person about their day at the childcare program/school, and often, children who have not been selected ask the licensing specialist(s) if they can talk to them.

Bureau staff believe it is important to interview children when monitoring childcare programs because children often provide us with valuable information about the care they receive, as well as important child care activities that we are unlikely to observe. The licensing specialist(s) ask questions about meals, snacks, activities, teachers, fire drills, rest, rules that children must follow, and what happens if children don't follow those rules.

MEDICAL INFORMATION

Please list any chronic conditions, allergies or medications that could be important in case of sudden illness or injury:

CHILD'S USUAL PHYSICIAN: _____ PHONE: _____
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, and in the event of a more serious illness or injury, I give my 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 childcare program personnel as soon as possible regarding any emergency involving my child.

Parent / Guardian Signature Date Signed

ANNUAL UPDATE: Parent/Guardian must review this information annually, make necessary changes and initial and date below to verify that the information is current.

REVIEW DATE PARENT/GUARDIAN INITIALS REVIEW DATE PARENT/GUARDIAN INITIALS

Dear Parent:

The Children's Center participates in the US Department of Agriculture's Child and Adult Care Food Programs, and therefore serves meals and snacks which meet or exceed the nutritional requirements set forth by the United States Government.

In return for serving meals and snacks which meet these requirements, the Center receives a reimbursement based on family income levels for each meal or snack served. The guidelines of income eligibility for free and reduced meals will change on July 1st. In order to determine the reimbursement rate the Center will be entitled to receive for the meals and snacks served to your child, the USDA requires that you complete the application form on the other side.

This application is strictly confidential and will only be used to determine the eligibility for free and reduced priced meals. By regulation, if any of the required information is not included when you complete the application form, the Center is only able to qualify your child for the lowest level of reimbursement for each meal and snack.

If the number of persons living in the household decreases, if the child for whom you are filing the application is terminated from either the Food Stamp or TANF grant under which he/she is currently covered, or if the total income to the household increases (or decreases) more than \$50 per month or \$600 per year, you must notify the Center and allow a re-determination of your child's eligibility. If you are filing the application for a Foster Child, please tell the Center. A Foster Child is eligible to receive service regardless of the income of the rest of the persons living in the family. The following shows the income levels to be used by the Children's Center for the period of **July 1, 2011 – June 30, 2012:**

REDUCED PRICE MEAL GUIDELINES FOR 2011-2012

	<u>Yearly</u>	<u>Monthly</u>	<u>Weekly</u>
1	\$ 20,147	\$1,679	\$ 388
2	27,214	2,268	524
3	34,281	2,857	660
4	41,348	3,446	796
5	48,415	4,035	932
6	55,482	4,624	1,067
7	62,549	5,213	1,203
8	69,616	5,802	1,339
For each additional household member add	+7,067	+ 589	+136

FREE MEAL OR FREE MILK GUIDELINES 2011-2012

	<u>Yearly</u>	<u>Monthly</u>	<u>Weekly</u>
1	\$ 14,157	\$1,180	\$ 273
2	19,123	1,594	368
3	24,089	2,008	464
4	29,055	2,422	559
5	34,021	2,836	655
6	38,987	3,249	750
7	43,953	3,663	846
8	48,919	4,077	941
For each additional household member add	+4,966	+414	+96

You may apply at any time during the year if your household size or income changes. You MUST let the Center know if your household size does go down or your income goes up by more than \$50 per month. You can simply call the office at 569-1027. You will not have to fill out another application.

Because the Center participates in the Child and Adult Care Food Program, it cannot discriminate against any child because of race, color, national origin, sex, age or disability. If you feel either you or your child have been discriminated against, write immediately to the Secretary of Agriculture, Washington, DC. 20250.

This form must be completed and returned with enrollment forms regardless of income. If your income exceeds the eligibility limit for your family size, you may write “Family income exceeds limit” in the Monthly income section of the form, but you must still list all family members.

**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
PARENT APPLICATION FOR CHILD(REN) ENROLLED IN DAY CARE**

(See reverse for instructions)

PART 1 - Child(ren) enrolled in the center: (Include Food Stamp or TANF case number, if applicable)

Child's Name (One application per household)	Age	Birth Date	Check if Applicable			Food Stamp or TANF Case # (if applicable)
			Foster Child	Food Stamp	TANF	

NOTE -- In most cases Foster Children are eligible for "free" or "Reduced-Price" meals regardless of household eligibility. If you are applying for a Foster Child, report only the child's personal income below (Part 2) not the money the family receives for general support for the child.

HOUSEHOLDS RECEIVING FOOD STAMPS OR TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF):

If you are **currently** receiving Food Stamps or TANF and if the above named children are included in the grant, write your Food Stamp or TANF case number above and complete Part 3. **DO NOT** complete Part 2. Part 3 **must** include the signature of the adult completing this application. If the Food Stamp or TANF grant is terminated you must notify the Child Care Center immediately to allow a redetermination of your CACFP eligibility.

PART 2 - CURRENT INCOME (See reverse side for explanation)

If you did **not** write a Food Stamp or TANF case number for all children listed above, complete Part 2. Sign and date the application in Part 3.

CURRENT GROSS MONTHLY INCOME

List the Names of Everyone in Your Household	Gross Earnings From Work* (Job 1)	Welfare, Child Support, Alimony	Payments from Pensions, Retirement, Social Security	Job 2 or Any Other Income
1.	\$	\$	\$	\$
2.	\$	\$	\$	\$
3.	\$	\$	\$	\$
4.	\$	\$	\$	\$
5.	\$	\$	\$	\$
6.				

* Self-employed - report **NET EARNINGS**

PART 3 - THE LEGAL GUARDIAN MUST SIGN THE APPLICATION BEFORE IT CAN BE APPROVED.

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Food Stamp number or TANF number is correct or that all income has been reported. I understand that this information is being given for the receipt of Federal Funds and that center officials may verify the information on the application and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Signature of Legal Guardian _____ Social Security Number** _____ Date Signed _____

Home Address or Mailing Address (if different) _____ Telephone (Home) _____ Telephone (Work) _____

** If the person signing this application does not have a Social Security Number, you must enter the word "NONE" in the space allotted for a Social Security Number. If a Food Stamp or TANF case number is provided, a Social Security Number is **not** required.

FOR CENTER USE ONLY -- DO NOT WRITE BELOW THIS LINE

(Monthly Income Conversion: Weekly X 4.33; Every Two Weeks X 2.15; Twice a Month X 2)

Food Stamp/TANF Household INCOME HOUSEHOLD: Total household monthly income _____ Household Size ____

APPLICATION APPROVED FOR: Free Meals Reduced-Price Meals APPLICATION DENIED BECAUSE: Income over allowed amount

Date Notice Sent: _____ TEMPORARY APPROVAL FOR: Free Meals, expires _____ Incomplete/missing _____
 Reduced-Price Meals, expires _____ Other _____

Signature of Determining Official _____ Date _____

Center Official **must** indicate approval category, sign and date on **this** form.