



Registration Requirements

In order to register your child, please complete all of the following:

Completed Registration Form	_____
Registration Fee * (\$100)	_____
Tuition Deposit * (\$450)	_____
Copy of Child's birth certificate	_____
Completed Medical Form signed by Physician	_____
Signed Tuition Agreement Form	_____

Please note that we cannot guarantee admission unless all of the above have been submitted.

Medical forms may need to be updated during the school year.

* Please note that Registration Fee and Tuition Deposit are non-refundable.
Tuition Deposit will be credited towards last month's tuition.

Email Address: _____

Contact Phone Number: _____



Tuition Agreement

Child's Name: _____

Date: _____

Class (Please choose):

2 – 11 months 12 – 18 months 19 – 24 months 25 – 35 months

Preschool
(3 Years) **Pre – K**
(4 Years) **Kindergarten**
(5 years) **After School**

9 AM – 12 PM **9 AM – 5 PM** **8 AM – 6 PM** **Other**

Tuition Due on: 1st of the month (September to May)

Please note that the \$100 registration fee and tuition deposit of \$450 are due at the time of registration.

All accounts must be current by the due date of each payment. There is no grace period. A late fee of \$25.00 will be assessed for any tuition received after the 10th of the month. Accounts not current by the 10th of the month will result in your child being withdrawn from the program until the account is paid. The registration fee and tuition deposit are non-refundable. A \$30.00 fee will be assessed for any checks returned from the bank.

I have reviewed the terms and conditions of this agreement, as stated. I understand and accept this agreement.

Name: _____

Signature: _____ Date: _____

CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

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. 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 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:
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)

Date Signed

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

NON-EMERGENCY ALTERNATE PICK-UP PERSON/S Continued

Name:	Name:
Relationship:	Relationship:
Address:	Address:
Phone number:	Phone number:

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 <http://childcaresearch.dhhs.nh.gov> or by calling the unit at 1-800-852- 3345, extension 9025 or 603-271-9025.

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 coordinator 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 provider, center director, site director or designee, and update annually, a signed dated statement indicating your preference.

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:

PARENT/GUARDIAN MUST REVIEW THIS INFORMATION ANNUALLY, 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:

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	

**If your child does not have health insurance, talk to your primary care provider or visit <https://nheasy.nh.gov>*

Is your child currently enrolled in WIC? Yes / No Does your child have health insurance? Yes / No*

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
- 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.
 - Do you have any concerns about your child's eating or sleeping habits?
 - Has your child had a dental exam in the past 6 months?
 - Does your child have any ongoing health problems (such as asthma, diabetes, or seizure disorder)?
 - Does your child have any allergies (to food, medication, insects, latex, etc.)?
 - Does your child require a special diet while in school or other early childhood program?
 - Does your child take any medications (daily or occasionally)?
 - Does your child have any difficulty with his/her vision, hearing, or speech?
 - In the past 12 months, has your child experienced any difficulty with wheezing or coughing?
 - In the past 12 months, have you been concerned about a change in your child's weight?
 - In the past 12 months, have you noticed any change in your child's appetite or thirst?
 - In the past 12 months, have you noticed that your child is urinating more frequently?
 - 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, , 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



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	<i>(must be taken within 60 days for WIC)</i>	lb / kg	Body Mass Index (BMI) <i>(if ≥ 2 years)</i>			
	HT	<i>(must be taken within 60 days for WIC)</i>	in / cm	<input type="checkbox"/> 5–84th % ile <input type="checkbox"/> 85–94th % ile	<input type="checkbox"/> < 5th % ile <input type="checkbox"/> ≥ 95th % ile		
	HC	<i>(if ≤ 2 years)</i>	in / cm	BP <i>(if ≥ 3 years)</i>	/	<input type="checkbox"/> Within normal range <input type="checkbox"/> ≥ 95th % ile	
				Please comment on any findings outside of normal range, including timeframe for re-evaluation, if applicable:			
		Normal	Follow-up				
		Yes	No	Indicated			
HEENT		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Dental/Oral health		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Cardiac		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Lungs		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Abdomen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Back/Extremities		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Breasts/Genitalia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Neurologic		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Skin		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Preventive Screening	HEARING	<i>PLEASE NOTE: Objective hearing screening beginning at age 4 years is REQUIRED for Head Start</i>				
	Date performed:	/	/	L	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Method: <input type="checkbox"/> Audiometry <input type="checkbox"/> OAE
				R	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	
	Was child referred for rescreen or further evaluation?		Y <input type="checkbox"/> N <input type="checkbox"/>		Does child wear a hearing aid? Y <input type="checkbox"/> N <input type="checkbox"/>	
	VISION	<i>PLEASE NOTE: Objective vision screening beginning at age 3 years is REQUIRED for Head Start</i>				
	Date performed:	/	/	L 20/ R 20/	Both 20/	Method: <input type="checkbox"/> Snellen <input type="checkbox"/> Other <input type="checkbox"/> Tumbling E
Was child referred for rescreen or further evaluation?		Y <input type="checkbox"/> N <input type="checkbox"/>		Does child wear glasses? Y <input type="checkbox"/> N <input type="checkbox"/>		
LABS	<i>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</i>					
	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 <input type="checkbox"/> Y <input type="checkbox"/>			
If yes, PPD result:		POS / NEG		Date: / /		
				DEVELOPMENTAL SCREENING <small>(e.g., ASQ, ASQ:SE, M-CHAT, PEDS)</small>	Date of screening: / /	
				Screening tool(s) used: <input style="width:100%;" type="text"/>		
				Typically developing: Y N Referred		
				Gross motor <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
				Fine motor <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
				Language/communication <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
				Problem-solving <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
				Social/emotional <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		

Special Needs	Chronic medical conditions/related surgeries?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<i>List special needs/considerations and medications below (other than in attached special care plans). Please attach Special Meals Prescription Form, if applicable.</i>
	Medications or treatments?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
	Allergies/sensitivities?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
	Behavioral issues/mental health diagnoses?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
	Limitations to physical activity?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
	Special equipment needs?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
	Special dietary requirements?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> Special care plan attached*	

Name, address, and telephone no. of primary health care provider (please print or use stamp):	Signature of Primary Health Care Provider _____ Date _____
<i>*Please attach any special care plans or other information</i>	



Wise Owl Academy
SMART CHILDREN • BRIGHT FUTURE

4 Merrit Parkway Nashua NH 03062 | (603) 883-3016

Food Allergies / Preferences

Please fill out the bottom of this form if there are certain foods or drinks that your child cannot have or that you prefer they not have in school. Please be sure to list items such as milk, eggs, peanut butter, baked goods, cheese, etc. We will be having activities and parties in school and want to be sure that your child does not eat any items that you do not approve of or your family.

Child's Name: _____

List Items Below:



Wise Owl Academy
SMART CHILDREN • BRIGHT FUTURE

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Photo Release Permission Slip

As a parent or guardian of this student, I hereby consent to using photographs/videotape taken during the school year and summer camp for educational purposes or distributing among school families. I do this with full knowledge and consent and waive all claims for compensation for the use or damages.

Yes, I give consent for Wise Owl to photograph my child for summer camp purposes and at school events.

No, I do not authorize Wise Owl to photograph for my child for any event.

Parent Signature: _____ Date: _____

Student's Name: _____