Wise Owl Academy

SMART CHILDREN • BRIGHT FUTURE

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

Summer Camp Registration Requirements

To register your child, please complete all of the following:

Completed Registration Form
Registration Fee * ($25)
First Week Payment * ($300) / ($175)
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 the Registration Fee and First Week Payment are non-refundable.

Full-Day Weekly fees are $300

Half-Day Weekly fees are $175

Parent 1 Email Address: ____________	Parent 2 Email Address: ____________
Parent 1 Phone Number: ___________	Parent 1 Phone Number: ___________

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Summer Camp Tuition Agreement

Child's Name: ____

Date: _________________________ Week #: _________________________

Full Day: Yes / No (Please choose one)

Weekly Camp Fees: $300 (Full Day) / $175 Half Day

Tuition is due on Monday for that week.

Please note that the $25 registration fee and tuition deposit of $300 for Full Day or $175 for Half Day 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 week has passed. Accounts not current by the end of the week will result in your child being withdrawn from the program until the account is paid.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 failed transactions.

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: Wise Owl Academy **LICENSE NUMBER:CCCB-06630**

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
Personal Email:	Personal Email:
Cell Phone Number:	Cell 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
Business Phone number: Hours:	Business Phone number: Hours:
Business Email:	Business 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:

New Hampshire Early Childhood Health Assessment Record

FOR USE FROM BIRTH THROUGH GRADE 3

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

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

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

Please print

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

Is your child currently enrolled in WIC? Yes / No

Does your child have health insurance? Yes / No*

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

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

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

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

PERMISSION TO EXCHANGE INFORMATION

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

Name of Program/School Requesting Information

Program/School Mailing Address

Signature of Parent/Guardian — Date

Program/School Telephone Number — Fax Number

Signature of Witness — Date

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

New Hampshire Early Childhood Health Assessment Record

Part II: PHYSICAL EXAMINATION, SCREENING, AND MEDICAL CONDITIONS

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

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

Physical Examination

WT	*(must be taken within 60 days for WIC)*	lb / kg	Body Mass Index (BMI) *(if ≥ 2 years)* ☐ *5–84th % ile* ☐ *85–94th % ile* ☐ *< 5th % ile* ☐ *≥ 95th % ile*
HT	*(must be taken within 60 days for WIC)*	in / cm	
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 *(e.g., ASQ, ASQ:SE, M-CHAT, PEDS)*

Date of screening: / /

Screening tool(s) used:

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

Special Needs

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

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

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

Signature of Primary Health Care Provider   Date

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

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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.

Parent Signature: ___________________________________ Date: _______________

Student's Name: ____

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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: