



Program Director:
Teneil Rineer

194 POLLARD ROAD
PO BOX 25
LINCOLN, NEW HAMPSHIRE 03251
(603) 745-8958
COMMUNITYCENTER@LINCOLNNH.ORG

Recreation Director:
Tara Tower
745-8673

AFTER-SCHOOL PROGRAM REGISTRATION & EMERGENCY INFORMATION:

PARENT/GUARDIAN: This form must be completed for each child enrolled in the program and must be updated whenever information changes.

DATE OF ENROLLMENT: _____

Participant's Name: _____ Date of Birth: _____ Age: _____ Sex: M() F()

Current Grade: _____ Email Address: _____ How often do you check email?: _____

Physical Address: _____ Town: _____ Zip Code: _____

Mailing Address: _____ Town: _____ Zip Code: _____

Mother's Name: _____ Home Phone: _____ Cell Phone: _____

Place of Work: _____ Work Phone: _____

Father's Name: _____ Home Phone: _____ Cell Phone: _____

Place of Work: _____ Work Phone: _____

SPECIAL INSTRUCTIONS FOR REACHING PARENT/GUARDIAN: 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. which number to call first.

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.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

NON-EMERGENCY ALTERNATE PICK-UP PERSONS:

I, _____ (Parent/Guardian Signature) authorize the following individual(s) to pick up my child on a non-emergency basis.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

MEDICAL INFORMATION:

Any medical conditions or allergies that may influence participation Yes () No ()

Please specify: _____

Is your child currently on any medication: Yes () No ()

Type of Medication: _____ Time it Needs to be taken: _____

Child's Physician: _____ Phone Number: _____ Address: _____

Insurance Company: _____ Policy Number: _____

PLEASE COMPLETE REVERSE SIDE

GENERAL AUTHORIZATIONS:

I give permission for my child to travel off property for field trips or other related recreational purposes:

Yes () No ()

The Lincoln-Woodstock Recreation Department has permission to use photos in which my child appears:

Yes () No ()

EMERGENCY MEDICAL TREATMENT AUTHORIZATION:

I hereby pledge for myself, my heirs, executors or administrators to waive and release all rights and claims for damages I may have against the agency. I also release the organization's agents, assigns or officials for any and all injuries suffered by my child. I hereby give permission for the staff and volunteers of the Lincoln-Woodstock Recreation Department to provide simple first aid treatment to my child

_____ (Print Participant's Name)

Should my child be taken to the hospital for emergency purposes, I hereby grant permission to the attending physician and staff to treat my child for anesthesia, medical, x-ray, and surgical procedures as may be deemed necessary or advisable. I understand that I will be contacted by program personnel as soon as possible regarding an emergency involving my child.

Parent/Guardian Signature:

Date:

If you are interested in **VOLUNTEERING** for this program, please indicate when you are available:

PARENTS/GUARDIANS PLEASE NOTE: The licensing agency 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 ext. 4624 or 603-271-4624.

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 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 site director a signed dated statement indicating your preference.

For more information about Child Care Licensing please visit our website at:
www.dhhs.state.nh.us/DHHS/BCCL/default.htm

CHILD HEALTH FORM
TO BE COMPLETED BY PARENT OR GUARDIAN:

CHILD'S LAST NAME _____ FIRST NAME _____ M.I. _____ DOB: MO ____ / DAY ____ / YEAR ____

CHILD'S ADDRESS _____
 WE/I _____ GIVE PERMISSION TO OBTAIN/RELEASE MEDICAL INFORMATION
 SIGNATURE OF PARENT/GUARDIAN ON THE ABOVE CHILD.

PLEASE RETURN TO: _____
 NAME OF CHILD CARE PROGRAM

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 POSTNATAL 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
PARENT MAY SUBSTITUTE A COPY OF CHILD'S IMMUNIZATION RECORD

VACCINE	DATE	DATE	DATE	DATE	DATE	DATE
DTP/DTAP						
HIB						
DTP-HIB						
TD						
OPV OR IPV						
MMR						
HEP-B						
VARICELLA						
OTHER						

COMMUNICABLE DISEASE HISTORY

RECOMMENDED SCREENING & TESTING OF ATTENDEES

DISEASE	DATE OF DIAGNOSIS	LABORATORY CONFIRMATION	PHYSICIAN		DATE	METHOD	RESULT:
CHICKENPOX		NOT APPLICABLE		TB (FOR HIGH RISK CHILDREN ONLY)			
OTHER:				VISION			
				HEARING			
				SPEECH			
				HIB/HCT		NOT APPLICABLE	
				URINE		NOT APPLICABLE	
				LEAD		NOT APPLICABLE	

HEALTH ASSESSMENT: (TO BE COMPLETED BY LICENSED HEALTH PRACTITIONER)

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	NORMA L	ABNORMAL	NEEDS FOLLOW-UP	NOT EXAMINED	CHECK () EACH LINE	NORMA L	ABNORMAL	NEEDS FOLLOW-UP	NOT EXAMINED
SKIN/SCALP					NOSE, THROAT, MOUTH				
NUTRITION					TEETH & GUMS				
NEUROLOGY & MUSCULAR					GLANDS INC. THYROID				
ORTHOPEDIC & SPINE					CHEST, BREASTS				
EYE					HEART, LUNGS				
EARS					ABDOMEN				
SPEECH					GENITALIA				

TEMPERAMENT: ___ EASY-GOING ___ AVERAGE ___ DIFFICULT

COMMENTS:

ALLERGIES: INCLUDE ALLERGIES TO FOOD, MEDICATION, OR OTHER SUBSTANCES:

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: _____

COMMENTS

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:				

PHYSICIAN'S SIGNATURE: _____

DATE OF EXAM: _____

PHYSICIAN'S NAME - TYPED OR PRINTED _____

TELEPHONE NUMBER _____

DATE OF NEXT SCHEDULED EXAM: _____