Trinity Life Community
A Foursquare Church

August 10, 2017

Dear Parent or Guardian,

We are delighted that your child will be enrolled in The Trinity Early Learning Center's Kindergarten class of 2017-2018! Our focus at The Trinity Early Learning Center is the holistic development of your child: socially, emotionally, mentally, physically and spiritually in a safe Christ-centered environment that nurtures wholeness, creativity, and learning.

To complete the enrollment process, please:

- Complete the TELC Child Care Registration and Emergency Information Form
- Have the child's physician complete the New Hampshire Early Childhood Health Assessment Record (electronic signature okay)
- Include your child's immunization record (must have before the 1st day of school/ electronic copy okay)
- Review the Tuition Rate Sheet and complete the Family Payment Plan
- Include the $300 non-refundable deposit with your application (new students only). Checks are to be made payable to Trinity Early Learning Center or TELC
- Return the completed documents to the Trinity Early Learning Center at 12 Station Road, Bedford NH 03110

The Next Steps:

- JOIN US **for Kindergarten Orientation** (Parents only please) on **Thursday, August 24 at 6:30** pm. At this brief informational meeting you can meet our kindergarten teacher- Kathy Walker, visit the classroom, view the curriculum, meet the other parents, and join us for a short Q & A session.

- GO SHOPPING with your child! Enclosed you will find a classroom supply list for Kindergarten

- SCHOOL STARTS on **Wednesday, August 30** at 8:15 AM. Student drop-off will be at the front of the building.

If you have any questions, or need assistance with the application, please contact myself, Rev. Linda Brady - Pastor of Christian Education at 603-622-6336 or telc@tlcnh.org

Sincerely,

Rev. Linda A. Brady

Rev. Linda A. Brady, MSED
Pastor of Christian Education

The Trinity Early Learning Center

CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

The Trinity Early Learning Center _____ CCCB-06779

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

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)* ☐
HT	*(must be taken within 60 days for WIC)*	in / cm	☐ *5–84th % ile* ☐ *85–94th % ile* ☐ *< 5th % ile* ☐ *≥ 95th % ile*
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*

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF OPERATIONS SUPPORT
BUREAU OF LICENSING & CERTIFICATION

Nicholas A. Toumpas
Commissioner

Mary P. Castelli
Senior Division Director

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9025 1-800-852-3345 Ext. 9025
FAX: 603-271-4782 TDD Access: 1-800-735-2964

CERTIFICATE OF RELIGIOUS EXEMPTION IN A CHILD CARE PROGRAM (IMMUNIZATIONS)

CHILD'S NAME_____ DATE OF BIRTH: _____ _____ _____
MONTH DAY YEAR

ADDRESS _____

The administration of immunizing agents conflicts with the above named child's religious beliefs. I understand that in the occurrence of an outbreak of vaccine-preventable disease in my child's child care program, the Bureau of Communicable Disease Control may exclude my child from the child care program, for his/her own protection, until the danger has passed.

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

I hereby affirm that this affidavit was signed in my presence on this _____day of _____20_____.

NOTARY PUBLIC SEAL

My Commission Expires:_____
Date

2017-2018 The Trinity Early Learning Center
Full-Day Kindergarten & Extended Care
Tuition Rate Sheet

Tuition Rates:

Full-day Kindergarten: The Tuition Cost is $4800 for the full school year (end of Aug – mid June) which includes tuition, curriculum, and morning and afternoon snack. For new students, a $300 deposit is due by August 15th or upon registration if later than August 15th. The remaining $4500 is due in one lump-sum payment or on a monthly basis (10 months beginning Sept 1st). For existing daycare students, the daycare tuition will convert to Kindergarten Tuition as of the start of school – the full $4800 may be paid in one lump-sum payment or in 10 equal monthly payments of $480 beginning September 1st.

Extended Care: Available for $10/day on a daily basis, from the end of the school day until 6pm – based on a contracted, pre-approved schedule and staff availability. Full-day Kindergarten children that are not picked up by 3pm will be sent to the extended care program and charged the daily rate of $10.

Other Fees:

Extended Care Fee: As needed, for children that are regularly picked up at the end of the school day that need to stay longer. The fee is $10 for the afternoon until 6pm.

Overtime Fee: $10 for every 5 minutes after 6pm.

Late Payment Fee: $10 per day that payment is not received, after the 15th of the month, unless prearrangements have been made with the administration. Continual late payments will result in termination of our contract.

Returned Check/ACH Fee: $30 plus any additional costs that may incur for a returned check.

Registration Fee: A $300 non-refundable fee is due upon registration and applied to the full Kindergarten tuition ($4800) for newly registered students.

Payment Schedules: Tuition payments may be made in one lump-sum payment, or on a monthly basis (for 10 months) beginning September 1st. Payment is due on the first of each month, but no late fees will be charged until after the 15th. Extended Care and Other Fees will be invoiced and must be settled the beginning of the month following the month in which they are incurred.

For Office Use Only:

Form Received:_____

Payment Received: _____

Entered: _____

2017-2018 Kindergarten Registration
Family Payment and Billing Information

Student's Name: Date of Birth:

Student's Name: Date of Birth:

PAYMENT AND BILLING:
Kindergarten Tuition is $4800 for the full School Year. Payment may be made via cash/check, credit card or via ACH, based on your preference of one Lump-Sum payment or 10 monthly payments.

SEE THE ATTACHED TUITION RATE SHEET FOR RATES AND OTHER FEES.

Please select payment method:

☐ Cash/Check ☐ Credit Card (complete reverse side) ☐ ACH (complete reverse side)

Please select payment frequency:

☐ One Lump-Sum ☐ Monthly

Monthly Payers, choose preferred payment date:

Choose 1st - 15th of month: _____

Checks may be made payable to **Trinity Early Learning Center** (or TELC). You will receive an immediate receipt for cash payments. Invoice receipts are available upon request.

For ACH/credit card - if you need to change the payment method, please contact us at least two days prior to the scheduled billing date.

Please list person(s) financially responsible for the student(s).

NAME(s):_____

ADDRESS:_____

_____

CELL PHONE:_____

HOME:_____

E-MAIL:_____

Relationship to the student: ( ) Parent ( ) Step-parent ( ) Grandparent ( ) Guardian/Other

By signing below, I agree to the payment terms indicated above. If payment is continually late or not made, I understand it can result in the withdrawal of my student(s). I have reviewed and understand the attached late fees.

_____ _____ _____

Signature Printed Name Date

2017 TELC Payment Authorization

CREDIT CARD PAYMENT AUTHORIZATION

I (we) hereby authorize TRINITY EARLY LEARNING CENTER (called "TELC" in this Authorization) to initiate recurring credit card charges to the below referenced credit/debit card account for the purpose of collecting childcare related payments. I (we) understand that the charges to the below referenced credit card account will be based on charges that are due and payable at the time of the credit card transaction. I (we) understand that this agreement is between myself (us) and the below referenced "TELC". I (we) authorize TELC to utilize Vantiv* to capture, create, and transmit all credit card information. I (we) indemnify and hold harmless, Vanitv from any and all liability resulting from any and all transactions. All disputes will be directed to and addressed by and between TELC and the below signed cardholder. I (we) understand that to properly affect the cancellation of this agreement, I (we) are required to give TELC written notice of revocation. A minimum of 5 business days is required to affect revocation.

Cardholder Name **Phone #** **Email if different than reverse side**

Account Number **Cardholder Billing Address** **Expiration Date**

City **State** **Zip** **Cardholder Signature** **Date**

ELECTRONIC FUNDS TRANSFER AUTHORIZATION (ACH)

I (we) authorize TRINITY EARLY LEARNING CENTER (called "TELC" in this Authorization to initiate debit entries to my (our) Checking or Savings account indicated below at the depository financial institution indicated below (called "DEPOSITORY" in this Authorization). I (we) authorize TELC to withdraw sufficient funds to pay my (our) regular childcare tuition and/or other childcare related fees that are due and payable. I (we) authorize TELC to use Bank of New Hampshire to process all payments. I (we) acknowledge that the origination of Automated Clearing House (ACH) transactions to my (our) account must comply with the provisions of United States Law. Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

Your Name **Phone #** **DEPOSITORY - Bank or Credit Union Name**

Address **Bank or Credit Union Address**

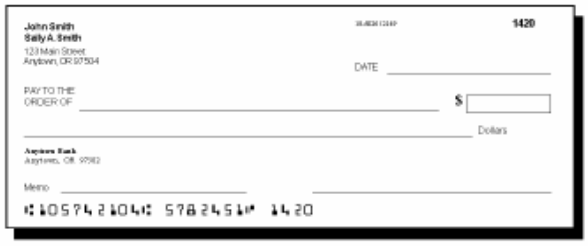
City **State** **Zip** **City** **State** **Zip**

Routing Transit Number **Account Number** **Checking or Savings** (circle one)

This authorization will remain in full force and effect until I (we) notify TELC in writing of its termination in such time and in such manner as to afford the Bank of New Hampshire and DEPOSITORY a reasonable opportunity to act upon it. Notices must be received at a minimum of 5 business days in advance of the termination date.

Signature **Date**

Please attach a copy of a voided check here. Deposit slips not accepted.



Routing Transit # Account # Check#

Record Retention Notice: TELC shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Vantiv or Bank of NH ACH program.

Vantiv is a secure online credit card processor and a leader in the industry. ACH payments are made through Bank of New Hampshire.

Trinity Early Learning Center Kindergarten Supply List

Miss Kathy picked all of these items for your child—
all of which can be purchased at Wal-Mart

Item	Number of Items	Cost per Item
Pink erasers– block style	2	0.48
Crayola 10-count makers (w/ 2 bonus)	1	2.77
Crayola Washable watercolors (tray & brush)	1	1.77
2-hole pencil sharpener (with fat pencil hole)	1	0.47
2-pocket folders (let child choose)	2	0.97
8-count Crayola crayons (regular size)	2	0.50
Child headphones (not earbuds)	1	Approx. 5.00
		Approximate Total: $15.00