



OFFICE USE ONLY
WEEKLY FEE: _____
CACFP: _____
REGION: _____

**2010/2011 AFTERSCHOOL APPLICATION**

DATE OF ENROLLMENT: \_\_\_\_\_

NAME: LAST	FIRST	DOB	AGE
STREET	CITY/TOWN	STATE	ZIP
MOTHER'S/GUARDIAN NAME		FATHER'S/GUARDIAN NAME	
EMPLOYER		EMPLOYER	
HOME ADDRESS		HOME ADDRESS	
WORK #	CELL #	WORK #	CELL #

EMAIL (PLEASE PRINT CLEARLY)

EMAIL (PLEASE PRINT CLEARLY)

**CONSENTS**

I authorize **GIRLS INCORPORATED** to contact the following person(s) who will assume responsibility for my child in the event I can not be reached immediately in an emergency:

Name: \_\_\_\_\_ Tele: \_\_\_\_\_

Name: \_\_\_\_\_ Tele: \_\_\_\_\_

I authorize **GIRLS INCORPORATED** to release my child to the following individuals other than parent or guardian:

Name: \_\_\_\_\_ Tele: \_\_\_\_\_

Name: \_\_\_\_\_ Tele: \_\_\_\_\_

I authorize **Girls Incorporated** staff to administer basic and temporary first aid to my child if necessary. In the event of a serious injury I give Girls Inc. permission to transport my child to a hospital or other emergency 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 Girls Inc. personnel as soon as possible regarding any emergency involving my child.

Yes \_\_\_ No \_\_\_

I give my child permission to attend local outings as part of the daily activities of **Girls Incorporated** program. (Park, playground, library, etc.) I understand that this information will be posted the day before the outing.

Yes \_\_\_ No \_\_\_

I authorize **Girls Incorporated** to publish my child's name and photograph in the newspaper, newsletter, web page or other promotional publications.

Yes \_\_\_ No \_\_\_

\_\_\_\_\_  
PARENT SIGNATURE

\_\_\_\_\_  
DATE

**MEDICAL INFORMATION**

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

**CHILD'S PHYSICIAN** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**Registration Information**

**Registration may be made in person or by mail** for the Afterschool Programs at Girls Incorporated in Nashua, Concord, Manchester and Rochester. A \$5.00 processing fee is required for participation. A **non-refundable** deposit of one week's fee is required at the time of registration and will be applied to the last week of service. Balances are due in full the Friday prior to the start of each week. **(Processing fees and deposits are non-refundable and non-transferable). Space is limited.**

**Financial Assistance:** Financial assistance is available to families who qualify. Eligibility is based on financial need and will require proof of income and completion of a Financial Aid Form (in. Girls Incorporated will notify parents if/when they are approved for assistance.

**Late pick-up fees:** Any families with late pick-ups will be charged \$5.00 for every 15 minutes late, per child. Excessive late arrivals may result in termination from the program. This fee is required at the time of pick up.

**Returned Check Fee:** Girls Inc. policy states that there is a \$40 returned check fee. This fee must be paid in cash plus the amount of the returned check.

**Health Forms:** The State of New Hampshire requires that all members have a completed health form on file with the office prior to attending the program. This form requires all immunization dates and a physical exam with a physician's signature. **Health forms are due no later than the Wednesday before the child begins the program.** A copy of the school health form including immunizations, if current, is acceptable.

**Licensing statement :** 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 bureau at 603-271-4624 or 1-800-852- 3345, extension 4624"; and 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 provider, center director, site director or designee, and update annually, a signed dated statement indicating your preference.

**I have read and fully understand the above polices.**

\_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**

**CONFIDENTIAL**  
**SCHOLARSHIP / FINANCIAL AID APPLICATION**

HEAD OF HOUSEHOLD

\_\_\_\_\_/\_\_\_\_\_  
 LAST NAME FIRST NAME M.I. HOME TEL. #

\_\_\_\_\_  
 STREET ADDRESS

\_\_\_\_\_  
 CITY STATE ZIP

Relationship to child(ren) \_\_\_\_\_

LIST ALL MEMBERS OF YOUR HOUSEHOLD	DATE OF BIRTH	CURRENTLY WORKING? <u>YES</u> OR <u>NO</u>	TOTAL GROSS MONTHLY INCOME (PLUS CHILD SUPPORT)	SOCIAL SECURITY NUMBER

Are you currently in a training or school program? \_\_\_\_\_ If YES, where? \_\_\_\_\_

**I certify, under penalty of perjury, that the above information is correct and complete to the best of my knowledge. I will immediately report to Girls Incorporated of New Hampshire any change in income or family size.**

\_\_\_\_\_/\_\_\_\_\_  
 Parent/Guardian signature Date

\_\_\_\_\_/\_\_\_\_\_  
 Staff signature Date

# Statistical Information

This information is optional but it is very important for our funding sources and will help us to identify services that you are not currently receiving, but for which you may be eligible. Any information that you provide Girls Inc. of New Hampshire will be kept confidential. Your cooperation is appreciated.

## Family Information

Parent Age:	<input type="checkbox"/> Under 18	<input type="checkbox"/> 19-25	<input type="checkbox"/> 26-32	<input type="checkbox"/> 33-39	<input type="checkbox"/> 40-50	<input type="checkbox"/> Over 50
Number in Household:	_____					
Family Configuration (living with):	<input type="checkbox"/> 2 parents	<input type="checkbox"/> Mother only	<input type="checkbox"/> Father only	<input type="checkbox"/> Step parent	<input type="checkbox"/> Foster	
	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Guardian	<input type="checkbox"/> Other _____			
Household Income:	<input type="checkbox"/> Under \$10,000	<input type="checkbox"/> \$10-14,999	<input type="checkbox"/> \$15-19,999	<input type="checkbox"/> \$20-29,999	<input type="checkbox"/> \$30-49,999	<input type="checkbox"/> over \$50,000
Parent highest education level completed:	<input type="checkbox"/> High School/GED		<input type="checkbox"/> College	<input type="checkbox"/> Post Graduate		
Main Language spoken at home:	_____					
Child Ethnicity:	<input type="checkbox"/> Black	<input type="checkbox"/> White	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Am	<input type="checkbox"/> Other _____
<input type="checkbox"/> Special Needs (please specify):	_____					

## Services

Please check all the services that your family is currently receiving.

- |   |  |
|---|--|
| <input type="checkbox"/> New Hampshire Child Care Scholarship | <input type="checkbox"/> Medicaid        |
| <input type="checkbox"/> USDA Free Lunch                      | <input type="checkbox"/> Food Stamps     |
| <input type="checkbox"/> Title I Services                     | <input type="checkbox"/> Fuel Assistance |
| <input type="checkbox"/> Educational Services (speech, ESL)   | <input type="checkbox"/> Section 8       |
| <input type="checkbox"/> Healthy Kids                         | <input type="checkbox"/> Public Housing  |

If you would like a referral to, or more information about, any of the services listed above, please complete the following:

Parent Name: \_\_\_\_\_ Address/Phone: \_\_\_\_\_

Services I'm interested in: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*Administrative Offices ~ 815 Elm Street, Suite 4A. ~ Manchester, NH 03101 ~ 603-625-1296  
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