

# 2017-2018 New Morning Registration and Emergency Information

This form must be completed for each of your children who will be enrolled in the program, and must be updated whenever information changes. A new form must be completed annually.

CHILD'S SCHOOL: \_\_\_\_\_

Has your family used New Morning programs in the past? Yes ( ) No ( )

CHILD'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

2017-2018

BOY( ) GIRL( ) GRADE: \_\_\_\_\_

( ) Preschool ( ) Kindergarten

( ) On-Site School Age ( ) IMAGINE ASP ( ) IMAGINE Camp ( ) Preschool Camp

I have read and understand the Parent Handbook.

My child and I agree to abide by all New Morning policies.

**MEDICAL INFORMATION:** List any chronic conditions, allergies or medications that could be important in case of sudden illness or injury. If your child requires any medication, we must have the following in our possession **before** your child's first day of attendance: The medication in its original container, medication orders from your child's doctor, an Authorization to Administer Medication form signed by a parent or guardian, and a photo of your child.

My child suffers from the following allergies:

Please submit a complete medical health care form separately. Forms may be faxed to 603-626-5377.

Please list all parents or guardians who are financially or legally responsible for this child. Include any information that is different from above.

Relationship to the child:

( ) MOM ( ) Grandparent ( ) Other \_\_\_\_\_

( ) Authorized to Pick up ( ) Emergency Contact

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

(If different from above)

EMAIL: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

WORK: \_\_\_\_\_ HOME: \_\_\_\_\_

Relationship to the child:

( ) DAD ( ) Grandparent ( ) Other \_\_\_\_\_

( ) Authorized to Pick up ( ) Emergency Contact

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

(If different from above)

EMAIL: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

WORK: \_\_\_\_\_ HOME: \_\_\_\_\_

**EMERGENCY CONTACT PERSON(S):** You are required to list at least one other person who could assume responsibility for your child if you could not be reached immediately in an emergency.

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CELL: \_\_\_\_\_

WORK: \_\_\_\_\_ HOME: \_\_\_\_\_

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CELL: \_\_\_\_\_

WORK: \_\_\_\_\_ HOME: \_\_\_\_\_

ALTERNATE PICK-UP PERSONS: The people listed below are authorized to pick up \_\_\_\_\_  
from the program with no verbal or written communication from me.

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CELL: \_\_\_\_\_

WORK:                      HOME:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CELL: \_\_\_\_\_

WORK:                      HOME:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CELL: \_\_\_\_\_

WORK:                      HOME:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CELL: \_\_\_\_\_

WORK:                      HOME:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CELL: \_\_\_\_\_

WORK:                      HOME:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CELL: \_\_\_\_\_

WORK:                      HOME:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CELL: \_\_\_\_\_

WORK:                      HOME:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CELL: \_\_\_\_\_

WORK:                      HOME:

**EMERGENCY MEDICAL TREATMENT AUTHORIZATION:**

I hereby give permission for the staff of New Morning 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. 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:

Occasionally, staff may want to use a photo of your child to decorate our bulletin board, to add a personal touch to your child's project, to promote our programs or to electronically share with you an image of your child creating, playing and having a great time at the program.

Please indicate if you give permission to have your child photographed for these purposes.

- I give permission to have my child photographed for project and display purposes.
- I give permission to have my child photographed for promotional purposes, including online.
- I give permission to have my child's image transmitted to me electronically.

To complete your child's registration, you must also submit the following:

- A Family Billing Form
- A Tuition Agreement for each program your child will attend (After School, Camp, etc.)
- A check in the amount of your child's required deposit.
- For children requiring medication, a signed Authorization to Administer Medication Form, along with the medication in its original container and medication orders from your child's doctor.
- A medical form with immunizations from your child's most recent physical.

Your child's complete registration packet must be submitted at least one week before your child's first day of attendance. For your child's safety, registration packets must be submitted to our business office, not to your child's school or directly to the program.

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 4624 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, an 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>



New Morning Schools, LLC  
[www.newmorningschools.com](http://www.newmorningschools.com)

23 Back River Rd Bedford, NH 03110  
Office: 669-3591 Fax: 626-5377  
[admin@newmorningschools.com](mailto:admin@newmorningschools.com)

Reminder - Please attach a copy of your child's most recent Health Form with Immunizations. Physicals must be dated June 2016 or later for children age 6 and older. Younger children require a physical dated no more than 1 year ago.

## 2017-2018 New Morning Schools Family Billing and Payment Information

CHILD'S NAME:

School(s):

Please list all siblings attending New Morning programs. Only one billing form is required per family.

**PAYMENT AND BILLING:**

We offer two options for paying for your child's care; you may pay weekly by cash, check or credit card; or auto-pay using Tuition Express.

**PLEASE SEE THE ATTACHED TUITION POLICY FOR PRICING AND PAYMENT DETAILS**

Please select one:

- Payment by Cash or Check

Please make checks payable to New Morning Schools, LLC. You will receive a receipt for cash payments. Call our office at (669-3591) if you would like to make a credit card payment.

- Auto-Pay

Please fill out either the Credit Card or EFT section on the back of this form. Tuition fees will be charged to your credit card, or deducted from your checking account, automatically unless alternative payment has been made by the scheduled billing date.

**Please see our complete Payment Policy on our website: [www.newmorningschools.com](http://www.newmorningschools.com)**

We do accept state scholarship payments, but you are responsible for all fees until state payments are made. We have no control over the payment amounts, and cannot bill until we receive all required paperwork. Please see your case worker with any questions.

**Please list all parents or guardians who are financially responsible for the children.**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

CELL PHONE: \_\_\_\_\_

Work: \_\_\_\_\_ Home: \_\_\_\_\_

Email: \_\_\_\_\_

Relationship to the child:  
( ) Parent ( ) Stepparent ( ) Other \_\_\_\_\_

Responsible for \_\_\_\_\_% of the bill.

We can only split payments by percentage.  
Both co-parents are required to use Tuition Express.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

CELL PHONE: \_\_\_\_\_

Work: \_\_\_\_\_ Home: \_\_\_\_\_

Email: \_\_\_\_\_

Relationship to the child:  
( ) Parent ( ) Stepparent ( ) Other \_\_\_\_\_

Responsible for \_\_\_\_\_% of the bill.

We can only split payments by percentage.  
Both co-parents are required to use Tuition Express.

We are excited to offer you the convenience of automatic tuition payments through Tuition Express. You'll no longer need to write a check or remember your checkbook when you're picking up your child at the end of a hectic day. Your payment will be processed safely and securely. Visit [www.tuitionexpress.com](http://www.tuitionexpress.com) for more information.

### CREDIT CARD PAYMENT AUTHORIZATION

I (we) hereby authorize New Morning Schools, LLC (called "CENTER" in this Authorization) to initiate recurring credit card charges to the below referenced credit 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 "CENTER". I (we) authorize CENTER to utilize Tuition Express\* to capture, create, and transmit all credit card information. I (we) indemnify and hold harmless, Tuition Express from any and all liability resulting from any and all transactions. All disputes will be directed to and addressed by and between CENTER and the below signed cardholder. I (we) understand that to properly affect the cancellation of this agreement, I (we) are required to give CENTER written notice of revocation. A minimum of 5 business days is required to affect revocation.

Cardholder Name	Phone #	Account Number
Cardholder Billing Address	Expiration Date	
City	State	Zip
Cardholder Signature		Date

### ELECTRONIC FUNDS TRANSFER AUTHORIZATION

I (we) authorize New Morning Schools, LLC (called "CENTER" 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 CENTER 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 CENTER to use the third party sender, Tuition Express\* 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	<input type="checkbox"/> Checking <input type="checkbox"/> Savings

This authorization will remain in full force and effect until I (we) notify the CENTER in writing of its termination in such time and in such manner as to afford Tuition Express 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.



Record Retention Notice: The child care provider 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 Tuition Express™ program.  
\*Tuition Express is an assumed business name of Blum Investment Group, Inc.

Rev. 06/2011

Routing Transit #    Account #    Check#