St. Peter's Home

300 Kelley St. Manchester, NH 03102 625-9313 /Fax 625-1910

sft@stpetershome.com

APPLICATION FORM

Name of Child _____ Nickname _____ Age _____ Sex _____

Due date of delivery _____ Date of Birth _____

Place of Birth _____ Child's Nationality _____

Home Address _____ City _____

State _____ Zip Code _____ Telephone _____

Brother _____ Age _____ Sister _____ Age _____

PARENT Marital Status (circle one) Single Married Separated Divorced Widowed

MOTHER Maiden Name _____

Place of Employment _____

Work Phone _____ Extension _____

Cell Phone _____

FATHER Name _____

Place of Employment _____

Work Phone _____ Extension _____

Cell Phone _____

How did you hear about St. Peter's Home _____

THIS ENTIRE PACKET WITH ALL FORMS COMPLETED AND $290.00 IS REQUIRED TO BE ACCEPTED ON THE WAITING LIST: $75.00 Registration Fee which is NONREFUNDABLE and $215.00 Security Deposit. If scheduled admission is not honored, the security deposit is NONREFUNDABLE.

Due to many circumstance, date of admission cannot be guaranteed. A confirmation letter will be mailed to you.

Interview Date _____ Possible Date of Admission _____ Date of Admission _____ Admission # _____ Computer # _____ Register # _____	Interviewer _____ Confirmation Date _____ Group _____

SECURITY MEASURES

St. Peter's Home will release children only to adults of at least 18 years of age. Children will be accompanied on the property at all times, until such time that they are left with their teachers. No children will be released without permission from the legal guardian(s).

DAY CARE ACTIVITIES

1. Bible Sessions
2. Computers
3. Educational Activities
4. Physical Education
5. Home Economics
6. Library
7. Music
8. Science
9. Spanish for Pre-K & Kindergarten
10. Sign Language
11. Dance ($8.00 per class weekly)
12. Gym ($8.00 per class weekly)
13. Workbench ($8.00 per class & cost of workbench kit)

PROTECTIVE MEASURES

Have there been any child support, custody, divorce, adoption, juvenile, paternity, litigation, or other court cases concerning your child? If yes, please identify each case by court, type of case and date, and explain each case:

_____

_____

Is there any other pending domestic violence, divorce, legal separation, separate maintenance, domestic relations, or other court cases concerning you and your spouse or any other parent? If yes, please identify each case by court, type of case and date, and explain each case

_____

_____

If there are any Court Orders or agreements concerning the child's custody and/or visitation, you are required to provide a copy of the Order or Agreement to the Director.

If while your child is enrolled at St. Peter's, a Court action arises involving your child, you, your spouse, or the other parent, must notify the Director immediately.

BIRTH CERTIFICATE

In order to register your child, parents must bring the child's Birth Certificate along with completed forms.

Do you receive any Human Services assistance? Yes _____ No _____

Type of Program _____Case Worker _____

FEE AGREEMENT & POLICIES

Revised:07/16/18

Absences
In the event your child is absent from St. Peter's, tuition payment is required in order to retain your child's placement in our program. A form must be filled out in the office for planned days and weeks absent. Any child that is absent for a week without notifying the Director will automatically be discharged on Friday of that week. Payment is due the week prior to the absence.

Admission
A full admission packet should be completed by the parent/guardian. No child will be admitted without proper documentation.

Allergies
If your child/children have any allergies you must inform Administration in writing. If child has an Epi-Pen parents must provide Physicican's Allergic Emergency Care Plan with Epi-Pen.

Arrival Time
Children should be in by 10:00 a.m., unless they have a Doctor's/Dentist appointment. Parents should notify office if their child will be late. Kindergarten and Pre-Kindergarten children should be in no later than 8:45 a.m.

Clothing
Please supply a change of clothing for your child at all times. Three changes for infants. Sneakers are the preferred shoe. No black soles, if they mark the floors.

Court Matters
A claim will be filed in small claims court for unpaid balances when a child leaves the program. Also, it's an administrative policy not to be involved in domestic relations litigation; therefore, employees of the home will refuse, as a matter of policy, to attend any court hearings.

Discharges
TWO FULL WEEKS paid notice is necessary for discharging a child from the program. (Please sign a discharge form at the Director's Office) If full 2 weeks is not received, Security Deposit will be forfeited. Note: The two weeks that St. Peters is closed for vacation in July does not count as a 2 week notice.

Hours
Open 6:30 a.m. to 5:30 p.m..
Beyond 9 hours a day, a fee of $2.00 per hour will be charged. If for any reason a child is left beyond 5:30 p.m. there will be additional charges ($1.00 per minute).

Holidays (Payable)
St. Peter's Home will be closed on :
Labor Day, Columbus Day, Veteran's Day, Thanksgiving Day, the day after Thanksgiving, Christmas Break, New Year's Day, Martin Luther King, Jr. Day, President's Day, Good Friday, and Memorial Day. In the event that a holiday falls on a weekend, we will
be closed on an alternate day.

Illnesses
We have full time First Aid Attendants on staff for the health and well being of your child. Each child shall be observed throughout the day for symptoms of illness and injury. If symptoms of illnesses such as more than one episode of vomiting/diarrhea in one day, or a temperature of 101 Fahrenheit or higher the child's parents shall be informed so that alternate arrangements can be made. When a child has been sent home with previous listed illnesses, he/she must be kept home until symptoms have subsided for at least 24 hours or longer. If your child has fever below 101 please provide necessary medication. We need written authorization for dispensing medication from parent and Child's Physician.

A child with a communicable disease will be taken to the Main Office and the parent will be contacted to pick up.

Lunch / Snacks
It is the parents' responsibility to provide lunch and two snacks daily for their child / children.

Medical
We require that all children's immunizations be up to date as appropriate for their age. The immunization schedule is as follows: 2 months; 4 months; 6 months; 15 months; 18 months; and 4-6 years of age. THE LICENSING DEPT. REQUIRES annual medical exams for all children.

Outdoor Play
We take the children out to play all year round except during inclement weather. Please provide proper clothing so that your child may enjoy the playtime outside. Parents will be notified if child / children do not have proper seasonal clothing. All children will be expected to play outdoors if attending school.

Release
Children are released only to parents/guardians. In the event of a need for an alternate person to pick up your child,

Administration must be notified and a signed form completed. Positive ID is required in order for the child to be released. Under no circumstances will a child be released to a minor (under 18 years old).

Re-Registration
Re-Registration is completed in February or March of each year. The $75.00 registration fee is paid yearly and is nonrefundable.

Rest Period
Nap time is a quiet time where the children are allowed to rest. We do not require that the child go to sleep, but the child must be quiet so others may sleep. Most children need to sleep because of the vigorous activities of the morning.

Tuition/Payment
$200.00 for one child from three years of age and up/must be completely toilet trained
$215.00 for one child ages six weeks through three years old and/or not toilet trained.

Weekly tuition must be received on Monday. An additional fee of $10.00 will be charged to your account for late payment.

St. Peter's Home has a Direct Payment Enrollment System. We greatly encourage parents to use this Direct Payment System. We do accept Bank generated check mailed to St. Peter's Home. Please note your child's name in the account/memo section of the check

Vacation
St. Peter's Home is closed every year the first two weeks in July. No tuition payment is required for these two weeks. Any other time your child is absent from our care, tuition payment imust be paid in advance. Note: These two weeks do not count as notice for discharging a child from the program. See "Discharges" section above.

Website
It is strictly prohibited for any person to photograph, videotape, or to take any other image, digital or otherwise, of any child not related to you, employee of St. Peter's Home, or of the facility for Distribution or posting in any way on any public or private website without the express written permission of St. Peter's Home.

Signed _____Witnessed _____Date_____

FEE AGREEMENT & POLICIES

Effective: 07/16/18
Revised: 05/14/18

A. **DAY CARE SERVICES:**

$200.00 for one child from 3 years old and up/must be completely toilet trained
$215.00 for one child 6 weeks old to 3 years old and/or not toilet trained

B. **DISCHARGES:**

TWO FULL WEEKS paid notice is necessary for discharging a child from the program. (Please sign a discharge slip at the Director's Office) Note: The two weeks that St. Peters is closed for vacation in July does not count as a 2 week notice.

C. **ABSENCES:**

PAYABLE AT ALL times in order to retain the child's placement.

D. **VACATION:**

THE HOME is closed the first 2 weeks of July (Non-Payable). Any other vacation or time off is payable. Note: These two weeks do not count as notice for discharging a child from the program. See "Discharges" section above.

E. **HOLIDAYS:** (Payable)

CLOSED on the following days: LABOR DAY, COLUMBUS DAY, VETERAN'S DAY, THANKSGIVING, the day after THANKSGIVING, CHRISTMAS BREAK, NEW YEAR'S DAY, MARTIN LUTHER KING JR. DAY, PRESIDENT'S DAY, GOOD FRIDAY AND MEMORIAL DAY. Closed on alternate days when the holiday falls on a weekend.

F. **MEDICALS:**

THE LICENSING DEPARTMENT REQUIRES annual medical exams for all children. The immunization schedule is as follows: 2 months; 4 months; 6 months; 15 months; 18 months; and 4 – 6 years of age.

G. **RE-REGISTRATION:**

In February or March of every year, notices will be posted to remind you to re-register your child/children for the coming school year. There is a $75.00 non-refundable fee paid yearly.

H. **CLOTHING:**

Please supply a change of clothing for your child at all times. Three changes for infants. Sneakers are the preferred shoe. No black soles, if they mark the floors.

I. **DAY CARE HOURS:**

Open 6:30 a.m. to 5:30 p.m.

J. **OVERTIME:**

Beyond 9 hours a day, a fee of $2.00 per hour will be charged. If for any reason a child is left beyond 5:30 p.m. there will be additional charges ($1.00 per minute.)

K. **PAYMENTS:**

Weekly tuition must be paid on MONDAY for the current week. Payments not received on MONDAY, $10.00 will be charged to your account.

L. **PROGRAM:**

Our program offers Parent / Teacher Conferences anytime during the year when a Parent or Teacher feels it is necessary.

M. **COURT MATTERS:**

I understand that should I leave the program with an unpaid balance, a claim will be filed in small claims. Also, it's an administrative policy not to be involved in domestic relations litigations, therefore, employees of the home will refuse as a matter of policy to attend any court hearings.

Signed:_____ Witnessed:_____ Date:_____

CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

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.

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)
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:

Younger (0-6 Months) Infant Schedule

Child's Name: _____ Date of Birth: _____
Today's Date: _____ Relationship to Infant: _____

Feeding

Liquids: ____ Breast Milk ____Formula, if so, primary brand: _____
Frequency of bottles: _____
Any tips for feedings: _____
_____
Have you started any solids? _____
Type and frequency of solids: _____
Have you discovered any allergies: _____
Any issues with frequent spitting up? _____ Acid Reflux? _____
Any other issues regarding feeding? _____

Sleep Habits

What time does your infant awake in the morning? _____
Frequency and length of naps: _____
Where does the infant nap at home?: _____
Do you try to provide: _____Complete Silence _____Soft Music _____Everyday Noises
Does your child take a pacifier? _____ Brand: _____ In Crib? _____
Any tips or routines for putting your child to sleep: _____
_____

General Health

How has your infant's general health been? _____
Have you experienced frequent ear infections? _____ Skin Irritations: _____
Any concerns with development? _____
_____

Is there anything else you might like to add to help us better serve you and your infant?

_____
_____
_____
_____
_____
_____

HEALTH QUESTIONNAIRE

PERSONAL HISTORY

1. Behavior:

   Temper tantrums:_____ biting_____ scratching_____

   Pulling hair _____ Other_____

2. Nap Time: _____ Length :_____ Nap toy:_____

3. Bowel Habits:

   Frequency of BM_____ usual time_____

   Constipation and / or Diarrhea _____

   Partially trained _____ completely trained _____

4. Socializing:
   Plays with others:_____ Prefers to play alone:_____

SPECIAL NEEDS

1. Vision (glasses) _____ 2. Hearing_____ 3. Speech_____
4. Activity Restrictions_____

MEDICAL HISTORY

1. Allergies:

   Food_____ Pollens _____

   Other_____

2. Illness: Measles_____ Mumps _____ Chicken Pox _____

   Diabetes _____ Whooping Cough_____ Other _____

3. Frequent colds or sore throat? _____
4. Ear Infections?_____
5. Respiratory conditions?

   Bronchitis _____ Pneumonia _____ Asthma_____

6. Seizure Disorder?_____
7. Hospitalizations? _____

   Surgery? (Explain)_____

8. Is there anything special we should know about your child's medical past?_____

   _____

   Emotional Development?_____

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 ON THE ABOVE CHILD.

PLEASE RETURN TO: **St. Peter's Home , 300 Kelley St. Manchester, NH 03102-3093**
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

DISEASE	DATE OF DIAGNOSIS	LABORATORY CONFIRMATION	PHYSICIAN
CHICKENPOX		NOT APPLICABLE	
OTHER:			

RECOMMENDED SCREENING & TESTING OF ATTENDEES

	DATE	METHOD	RESULT:
TB (FOR HIGH RISK CHILDREN ONLY)			
VISION			
HEARING			
SPEECH			
HIB/HCT		NOT APPLICABLE	
URINE		NOT APPLICABLE	
LEAD		NOT APPLICABLE	

HEALTH ASSESSMENT:

CHILD'S NAME:
PHYSICAL EXAM:

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____IN/CM %ILE_____	_____LB/KG %ILE_____	_____IN/CM %ILE_____	_____ /_____

CHECK( ) EACH LINE	NORMAL	ABNORMAL-	NEEDS FOLLOW-UP	NOT EXAMINED	CHECK EACH LINE:	NORMAL	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:				

PRINT PHYSICIAN'S NAME _____ DATE OF EXAM _____

PHYSICIAN'S SIGNATURE _____ DATE OF NEXT EXAM _____

State of New Hampshire
Department of Health and Human Services
Division of Public Health Services
Bureau of Child Care Standards and Licensing

AUTHORIZATION TO ADMINISTER PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

Child Care Agency Name St. Peter's Home Phone 603-625-9313

Child's Name _____ Date of Birth _____

INSTRUCTIONS: Medication shall be administer in accordance with He-C 4002.15 (m) 1 through 10

Parent's Authorization

I authorize child care personnel at St. Peter's Home to administer the
Child Care Agency

Following medications to my child:

Name of Medication	Amount	Times	Dates(s) From	To

Parent/Guardian Signature _____ Date_____

MEDICAL HEALTH PRACTITIONER'S AUTHORIZTION TO ADMINISTER NON-PRESCRIPTION MEDICATION
When medication is to be administered differently than as directed by the manufacturer's printed instructions. The non-prescription medications(s) listed below may be administered.

LIST MEDICATIONS AUTHORIZED	DOSAGE	DURATION OR DATE AUTHORIZATION ENDS

Special instructions for Administration _____

Signature of Licensed Health Practitioner _____ Date Signed _____

CHILD CARE AGENCY RECORD OF MEDICATION

(to be completed by child care personnel for all medication administered)

Name of Medication	Amount	Time	Date	Initials	Name of Medication	Amount	Time	Date	Initials

Childs Name: _____

I understand that I will be issued 2 key fobs to have access to St. Peters home during business hours.

Key Fob #1 Name: _____

Key Fob # 2 Name: _____

I am also requesting 1 additional fob @ $10.00: _____YES _____NO

Additional Fob # 3 Name: _____

Signed: _____

Date: _____

St. Peter's Staff use only:

Key Fob #1: _____

Key Fob #2: _____

Key Fob #3: _____

Saint Peter's Home

300 Kelley Street • Manchester, New Hampshire 03102
Administration (603) 669-1219 • Business Office (603) 625-9313

Dear Parent,

At St. Peter's Home we have implemented a service called "ONE CALL NOW "this is a mass notification system that will notify all parents by text, voice or e-mail, immediately in the event of an emergency situation. The following are instructions on how to "log on"to the service to add or make changes to your information to keep it current and how to opt in to receive text messages. This can only be done after your account has been created by St. Peter's.

To "log on" to one call now you will need to go St. Peter's home page on the web (stpetershome.com) and click the center link of the one call now banner. This will bring you to a "log on" page, then enter the last name of your child and the 4 digit ID#/security code which will be given to you by administration. The ID /security code number cannot be changed because it is your child's file number so put it somewhere safe. Once you "log on" you will be able to add or make changes to your phone numbers and e-mail information ONLY, after you submit those changes it will be sent to administration for approval to be added to our roster.

If you wish to receive text messages you must "OPT IN " for this service , (Cell service providers require that members agree to receive text messages from one call now before they can contact you .standard text messaging rates may apply according to your provider).To "OPT IN " simply text the word ALERT to 22300. You should receive a message immediately from one call now notifying you that you will begin to receive text messages.

We are very excited to be able to offer this service to you. We hope it gives you a greater sense of security knowing this service is in place. Please don't hesitate to contact us if you have any questions or concerns.

Thank You,

Sr. Florence Therrien

Sr. Florence Therrien

Childs Name: _____

Phone #1: _____ Description: _____

#2_____ _____

#3_____ _____

E-Mail #1_____ _____

#2_____ _____

#3_____ _____

Example:

Phone #1 555-555-5555 Mom's Cell / Dad work / home ect.

E-Mail #1 Janedoe@comcast.net Mom / Dad / Mom work ect.

Direct Payment Enrollment

___ New Enrollment ____Change Request

Name _____ Social Security Number_____
Address_____
City_____ State_____ Zip_____

I hereby authorize *(company/organization)*_____
(hereinafter called "Originator") to initiate debit entries and to initiate, if necessary, adjustment credit entries to my account at the depository institution named below (hereinafter called "Depository") for the purpose of _____.

PRIMARY ACCOUNT:
Depository Name *(Bank or Credit Union)*
Name: _____
Address: _____
Routing Number:_____

Account Type: *(check one)* ACCT. #_____
___ Checking ____ Savings

Amount to Debited:
$_____ *(fixed amount)*

This authority is to remain in full force and effect until the Originator has received written notification from me of its termination in such time and in such manner as to afford Originator and Depository Institution a reasonable opportunity to act upon it. Originator reserves the right to terminate this agreement at any time upon notification.

Signature: _____ Date: _____

Rev. 10 / 07