

Goddard Riverside

INVESTING IN PEOPLE, STRENGTHENING COMMUNITY

August 2025

Dear Parents/Guardians:

We are pleased to announce registration for the After School Program 2025-2026 for children in grades K-6. The After School Program will operate from September 10th, 2025 (tentative) through June 12th, 2026, Monday — Friday, 2:45pm to 5:45pm on regular school days.

Registration is open and will continue until all spaces are filled. You can pick up an application at the Lincoln Square Neighborhood Center (250 West 65th Street). Forms will also be available for download from our website <http://www.goddard.org>

If you have questions, please email LSNCYouth@Goddard.org.

\$50 Registration Fee due with application submission. **ALL PAYMENTS ARE NON- REFUNDABLE.**

- Amsterdam Houses Residents: \$150/Month, \$1,350/ Year (**Must show proof of residence**)
- Returning After School Participants: \$200/ Month, \$1,800/ Year
- New Participants: \$275/ Month, \$2,475/ Year
- We also accept **HRA vouchers and child care vouchers** as forms of payment.

There is a 10% discount (with a 20% max) for the following:

- Each sibling registered
- Payment for two or more months made in advance (this discount is included in yearly amount above)

We will have escort service from the following schools at no additional cost:

- **PS 199, PS 452, PS 191 & Special Music School**

The following will be needed to complete registration:

- \$50 Non- Refundable Registration Fee/ Family
- Registration Contract
- Income Eligibility Form (CACFP Snack Form)
- Health Examination Form (current within 1 year with Immunization Records)
- Copy of most recent report card or school progress report
- Proof of Income (2024 W-2 or 2 recent pay stubs or Budget Letter)
- Attendance at Mandatory Parents' Orientation in September - **Date TBA**

Tutoring is available at the Star Learning Center for second grade and up, contact Monica Enciso for information at 212-799- 2369, menciso@goddard.org. We also provide full day services from 8:00am to 6:00pm during the public school mid-winter and spring recesses. Additional fees apply for these services.

For registration and information about our 3-K For All, Pre-K, and programs for 2-year-olds, call (212) 712-9306 or email LThornton@goddard.org. For inquiries specifically about our programs for 2 – 5-year-olds, you can also email GRCCEarlyLearn@goddard.org

Sincerely Yours,

Tamika Gayle
Director, Youth Services
Lincoln Square Neighborhood Center

Goddard Riverside

INVESTING IN PEOPLE, STRENGTHENING COMMUNITY

Agosto de 2025

Estimados Padres / Guardianes:

Nos complace anunciar la inscripción para el programa después de la escuela 2025-2026 para niños de 5 a 12 años. El Programa Después de la Escuela funcionará desde el 10 de septiembre de 2025 hasta el 12 de junio de 2026, lunes - viernes, de 2:45pm a 5:45 pm los días escolares regulares.

La inscripción esta abierta hasta que los cupos se agoten. Aplicaciones estaran disponibles en Lincoln Square Neighborhood Center (250 West Calle 65th) Los formularios también estarán disponibles para descargar desde nuestro sitio web <http://www.goddard.org>

Si tiene preguntas, comuníquese con lsncyouth@goddard.org.

Precios: El pago \$50 para registrar su hijo/a cuando entregues la aplicacion. No hay devoluciones de dinero.

Para los que son:

- Residentes de Amsterdam Houses: \$150/ mensual,\$1,350/ anual (**Debe mostrar comprobante de domicilio**)
- Participantes que regresan al program despues de la escuela: \$200/ mensual,\$1,800/ anual
- Participantes nuevos: \$275/ mensual, \$2,475/ anual
- También aceptamos vales de **HRA** y vales de cuidado infantil como forma de pago.

Hay un descuento del 10% (con un máximo del 20%) para lo siguiente:

- Cada hermano registrado
- Pagos completos de dos meses o mas (se incluye tambien para un pago anual)

Buscaremos participantes de las siguientes escuelas a ningun costo a usted:

PS 199, PS 452, PS 191 y Special Music School

Lo siguiente será necesario para completar el registro:

- Pago del primer mes de programa. (descuento de 10% si paga por dos meses)
- Contrato de registro
- Formulario de Elegibilidad de Ingreso Formulario de Solicitud de Tutoría (Grados 2-5)
- Formulario de examen de salud (actual dentro de un año)
- Copia de la boleta de calificaciones más reciente o informe de progreso de la escuela
- Prueba de Ingresos (2024 W-2 o 2 recibos de pago recientes o Carta de Presupuesto.
- Asistencia obligatoria a la orientación de los padres en septiembre - Fecha no decidida

La tutoría está disponible en el Centro de Aprendizaje de Estrellas para el segundo grado y en adelante. Comunicarse con Monica Enciso para obtener información al 212-799-2369, menciso@goddard.org. También ofrecemos servicios de día completo de 8:00 am a 6:00 pm durante cierre de la escuela pública a mediados de invierno y recesos de primavera. Se aplican cargos adicionales por estos servicios.

Para registrarse y obtener información sobre nuestros programas de 3-K For All, Pre-K y programas para niños de 2 años, llame al (212) 712-9306 o envíe un correo electrónico a LThornton@goddard.org. Para consultas específicamente sobre nuestros programas para niños de 2 a 5 años, también puede enviar un correo electrónico a GRCCEarlyLearn@goddard.org.

Tamika Gayle

Directora, Servicios para adolescentes

El Centro de Vecindad de Lincoln Square

Goddard Riverside

INVESTING IN PEOPLE, STRENGTHENING COMMUNITY

AFTER SCHOOL PROGRAM/LSNC
REGISTRATION CONTRACT 2025-2026/
PROGRAMMA DEPUES DE LA ESCUELA
CONTRATO DE REGISTRO 2025-2026

Completes

Registration Date/ Fecha de hoy					
PARTICIPANT INFORMATION/INFORMACIÓN DEL PARTICIPANTE					
Last Name/ Apellido			First Name, Middle/ Nombre, Inicial		
Home Address/ Dirección				Apt/ Apto	
City/Cuidad	Manhattan	Queens	Bronx	Brooklyn	Staten Island
State/Estao	☐ NY ☐ NJ ☐		Zip Code/ Codigo Postal		
Home Telephone/ Teléfono de su casa					
Housing/ Vivienda	Rental/Alquiler Other/Otro		NYCHA Housing/Proyectos NYCHA [2 Family Owned/ Propiedad Familiar		
Age/Edad		Gender/Sexo			
Date of Birth/ Fecha de Nacimiento (mm/dd/yyyy)			Primary Language Spoken/Lenguaje Principal		
Current Grade/ Grado		School/ Escuela			
Classroom/ Aula			Teacher's Names/ Nombre de la Maestra(o)		
School Type/ Tipo de Escuela	[] Public/Publica. [] Parochial/Parroquial		[] Charter/Carta [] Home School	[] Private/Privada [] Other/Otro	
Does Child have an IEP	Yes / No		If Yes, date of recent evaluation		
Does Child have a 504 Plan?	Yes / No		If Yes, date of recent plan		

Lincoln Square Neighborhood Center
250 West 65th NY, NY 10023
(212) 874-0860
LSNCYouth@Goddard.Org

Race/ Raza (Select All That Applies)	☐ American Indian or Indigenous American ☐ Asian ☐ Black or African-American ☐ Pacific Islander or Native Hawaiian ☐ White or Caucasian ☐ Other / Multi-Race. _____		
Ethnicity/ Etnicidad	☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino		
Any Medical Conditions/Allergies/ Alguna condición medica/Alergias	Yes / No	If yes explain/ Sies si porfavor de explicar	

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AFTER SCHOOL PROGRAM/LSNC
REGISTRATION CONTRACT 2025-2026/
PROGRAMMA DEPUES DE LA ESCUELA
CONTRATO DE REGISTRO 2025-2026

Youth's Last Name/ Apellido		Youth's First Name/ Nombre	
PARENT/GUARDIAN INFORMATION/INFORMACION DEL PADRE/GUARDIAN			
Primary Parent/Guardian			
Last Name/ Apellido		First Name/ Nombre	
Relationship/Relación			
Home Telephone/Teléfono de la casa			
Cell/Other Telephone/Teléfono del celular			
Business Telephone/Teléfono del trabajo			
Email Address/Coreo Electronico			
Primary Language Spoken/ Lenguaje Primario			
Are you a registered voter? /¿Usted esta registrado para votar?			Yes / No
Are you or any member of your household (0-64 years of age) covered by Medicaid, Child Health Plus, Family Health Plus or private medical insurance? / ¿Usted o algún miembro de su familia (de 0-64 años) tienen el seguro de Medicaid, Child Health Plus, Family Health Plus o seguro médico privado?			Yes / No
Additional Contact			
Last Name/ Apellido		First Name/ Nombre	
Relationship/Relación			
Home Telephone/Teléfono de la casa			
Cell/Other Telephone/Teléfono del celular			
Business Telephone/Teléfono del trabajo			
Email Address/Coreo Electronic			

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AFTER SCHOOL PROGRAM/LSNC
REGISTRATION CONTRACT 2025-2026/
PROGRAMMA DEPUES DE LA
ESCUELA CONTRATO DE REGISTRO
2025-2026

Youth's Last Name/ Apellido		Youth's First Name/ Nombre	
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EMERGENCY CONTACTS & DISMISSAL AUTHORIZATION / CONTACTOS DE EMERGENCIA Y AUTORIZACIÓN PARA RECOGER A LOS NIÑOS

Please provide us with a list of additional names and telephone numbers of alternate persons whom we may contact in case of emergency. Designate any of these people as authorize to pick up your child by checking the box beside their name. I will notify Goddard Riverside Community Center if there are any changes in the persons named in emergency contacts and dismissal authorizations Parent/Guardian is automatically included as an authorized person. Authorized escorts under 14 old years of age will be allowed at the Program's discretion. / Por favor provenos con una lista de nombres y telefonos de personas que podemos llamar en caso de emergencia y que pueden recoger a su hijo(a) del programa. Yo notificaré a Goddard Riverside Community Center si hay cambios en los nombres de las personas que estan en los contactos de emergencia y autorización de partida. Padres/Guardianes están automáticamente incluidos como personas autorizadas. Escortas autorizadas menos de 14 años de edad serán permitidos a la discreción del programa.

Last Name/Appellido	First Name/Nombre	Telephone/Telefono	Relationship/ Relación	Pick Up/ Recojer
I give permission for my child to walk home alone. / Yo autorizo a que mi hijo/a camine solo a su casa.				Yes / No
Child may not be picked up by: /El nino no puede ser recogido por:				

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AFTER SCHOOL PROGRAM/LSNC
REGISTRATION CONTRACT 2025-2026/
PROGRAMMA DEPUES DE LA
ESCUELA CONTRATO DE REGISTRO
2025-2026

Youth's Last Name/ Apellido		Youth's First Name/ Nombre	
PARENT/GUARDIAN CERTIFICATION & AGREEMENT/ CERTIFICACIÓN Y ACUERDO		DEL PADRE O GUARDIÁN	

Last Name/APELLIDO	First Name/NOMBRE	Relationship/ Relación

As a condition of registration of my child in the PROGRAM of GODDARD RIVERSIDE COMMUNITY CENTER (CENTER), I agree to the following:/Como condición del registro de mi hijo(a) en el PROGRAMA en GODDARD RIVERSIDE COMMUNITY CENTER, yo convengo lo siguiente:

All of the given information on registration contract is correct. I will follow program rules and regulations including making adequate arrangements to have young children picked up at dismissal time. I will, to the best of my ability, support my child's participation and development and will communicate with the CENTER to accomplish these goals. /Toda la información en el contrato de registraci3n esta correcta. Yo entiendo las reglas y polizas y voy a hacer lo mejor posible para recoger a mi hijo(a) a tiempo al la hora de partida del programa. Yo voy hacer lo mejor posible para apoyar a mi hijo(a) durante su participaci3n en le programa.

PARTICIPATION/ PARTICIPACIÓN: I agree to participate in Parent/Family Events including attending meetings, volunteering or contributing to special events. /Yo participaré en las Actividades de los Padres lo cual incluye reuniones, ser voluntario o contribuir a evento especiales.

TRIP PERMISSION/ PERMISO PARA PASEOS: I hereby give my child permission to participate in all program activities, field trips, sports, arts, recreation and events with the CENTER during regular program hours, within the New York City/Tri State area. /Yo doy permiso para que mi hijo(a) valla a los paseos con el programa durante las horas regulares.

WAIVER/ RENUNCIA: I hereby authorize Goddard Riverside Community Center and DYCD or any of its designees to photograph and record, both digital and analog, my child for any and all purposes in connection with Goddard Riverside Community Center and DYCD. I agree to hold Goddard Riverside Community Center and DYCD harmless from any liability arising out of photographs, digital images, videos and recordings and waive any compensation for pictures, printed works or audio/visual products of or by my child. /Yo autoriz3 a Goddard Riverside Community Center y DYCD que retrat3 o grabe a mi hijo(a) para todo los propositos en conexi3n a Goddard Riverside Community Center. Estoy de acuerdo con mantener a Goddard Riverside Community Center y DYCD libre de toda responsabilidad que pueda surgir de las fotografías, imágenes, videos y grabaciones de mi hijo(a).

MEDICAL AUTHORIZATION/ AUTORIZACIÓN MEDICA: In the event of an emergency, and after every attempt has been made to contact me, I hereby give permission for the agency, Goddard Riverside Community Center, to get medical treatment for my child. I further authorize the doctor or the hospital to which my child may be brought and whomever they may designate as their assistant, to perform any emergency procedure or operation on my child during their attendance in the Goddard Riverside Community Center program. /En el evento de una emergencia, y después de que todos los medios de comunicarse conmigo sean agotados, yo le doy permiso a la agencia de Goddard Riverside Community Center de obtener atención medica para mi hijo(a). Además autorizo al medico y al hospital que pueden hacer cualquier procedimiento de emergencia o cirugía durante su asistencia en Goddard Riverside Community Center.

Parent/Guardian Signature/ Firma del Padre/Guardián

_____/_____/_____
Date/Fecha

Youth's Last Name/ Apellido		Youth's First Name/ Nombre	
PROGRAM FEES/HONORARIOS DEL PROGRAMA			
Gross Annual Income		Number of People In Household	
FEE			
Resident of Amsterdam Houses/NYCHA		\$150/ Month	
Returning After School Participants		\$200/ Month	
New Participants		\$275/ Month	
Program Discounts. Check all that apply. Each entry is a 10% discount from total fee with a maximum of 20% discount.			
☐ Two (or more) Month's of Tuition Paid In Full* payments are due on the first business day of every month.			
☐ Enrolling one or more siblings in LSNC After School Program			
Financial Assistant Organizations			
HRA/ACS Household			
All payments are due on the first business day of the month!			
* I agree to pay the program fees to Goddard Riverside Community Center for the registration of my child in the After School Program. A non-refundable deposit of \$50 is required at time of registration. Please select recommended payment options. Other arrangements can be discussed. I understand if I do not make the appropriate payments, my child may be dropped from the program. Once tuition is paid, there are NO REFUNDS! Yo me comprometo a pagar el costos a Goddard Riverside Community Center por el ingreso de mi hijo/ a en el programa después de la escuela. La tasa de inscripcion no reembolsable de \$50.00 un depósito se requiere en el momento de registrar al niño/a en el programa. Por favor seleccione de las recomendaciones para pagar a continuación. Otros arreglos se pueden discutir. Yo entiendo que si no hago los pagos a los que me comprometí, mi hijo/a podría ser removido del programa. / Once tuition is paid, there are NO REFUNDS!			
_____ Parent/Guardian Signature/ Firma del Padre/Guardián		____/____/_____ Date/Fecha	

INCOME ELIGIBILITY FORM
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: Goddard Riverside Community Center

Print the name of the child(ren) enrolled in this child care center:

1. _____ 2. _____ 3. _____

Complete SECTION A if
anyone in your household:

1. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. If any of the children enrolled in this child care center are foster children

Section A		Section B	
Food Stamp Case Number TANF Number FDPIR Number Names of Foster Children An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below. I certify that the above information is true. I understand that the center will get Federal funds based on the information I give. Signature: Date:		List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received last month in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.	
		Name of Household Members	Month Gross Income
		1.	
		2.	
		3.	
		4.	
		5.	
		6.	
FOR SPONSOR USE ONLY			
Sponsor Agreement Number Total Household Members (Including foster children, if applicable) Total Income \$ Free Reduced Paid Date Determined Signature of Center Staff		An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below. I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give. Signature: Print Name: XXX-XX- Date:	

CHILD & ADOLESCENT HEALTH EXAMINATION FORM NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION										Please Print Clearly NYC ID (DSIS)									
TO BE COMPLETED BY THE PARENT OR GUARDIAN																			
Child's Last Name				First Name				Middle Name				Sex: ☐ Female ☐ Male		Date of Birth (Month/Day/Year)					
Child's Address								Hispanic/Latino? ☐ Yes ☐ No		Race (Check ALL that apply): ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other									
City/Township				State		Zip Code		School/Center/Camp Name Goddard Riverside Comm Ctr				District Number		Phone Numbers Home: _____ Work: _____					
Health Insurance: ☐ Yes (including Medicaid?) ☐ No				Parent/Guardian: Last Name _____ First Name _____				Email _____				Cell _____		Work _____					
TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER																			
Birth history (age 0-6 yrs) ☐ Uncomplicated ☐ Premature: _____ weeks gestation ☐ Complicated by _____ Allergies: ☐ None ☐ Epigen prescribed ☐ Drugs (list) _____ ☐ Foods (list) _____ ☐ Other (list) _____				Does the child/adolescent have a past or present medical history of the following? ☐ Asthma (check severity and attack pattern: If consistent, check all current medications) ☐ Allergic Control Status: _____ ☐ Anaphylaxis ☐ Behavioral/mental health disorder ☐ Congenital or acquired heart disorder ☐ Developmental/learning problem ☐ Diabetes (specify type) ☐ Orthopedic injury/disability ☐ Explain all checked items above. ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None ☐ Well-controlled ☐ Poorly Controlled or Not Controlled ☐ Seizure disorder ☐ Speech, hearing, or vision impairment ☐ Tuberculosis (past infection or disease) ☐ Hospitalizations ☐ Surgery ☐ Other (specify) _____ ☐ Addendum attached.															
Attach MAP in in-school medications needed				Medications (specify and if in-school medication needed) ☐ None ☐ Yes (list below)															
PHYSICAL EXAM Date of Exam: ____/____/____ Height: _____ cm _____ %ile Weight: _____ kg _____ %ile BMI: _____ kg/m ² _____ %ile Head Circumference (age <2 yrs): _____ cm _____ %ile Blood Pressure (age >2 yrs): ____/____/____				General Appearance: ☐ Physical Exam WNL ☐ As Above ☐ Psychosocial Development ☐ As Above ☐ Language ☐ As Above ☐ Behavioral ☐ As Above ☐ HEENT ☐ As Above ☐ Dental ☐ As Above ☐ Neck ☐ As Above ☐ Lymph nodes ☐ As Above ☐ Lungs ☐ As Above ☐ Cardiovascular ☐ As Above ☐ Abdomen ☐ As Above ☐ Genitourinary ☐ As Above ☐ Extremities ☐ As Above ☐ Skin ☐ As Above ☐ Neurological ☐ As Above ☐ Back/Spine															
DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? ☐ Yes ☐ No Screening Results: ☐ WNL ☐ Delay or Concern Suspected/Confirmed (specify, attach below): ☐ Cognitive/Problem Solving ☐ Adaptive/Self-help ☐ Communication/Language ☐ Gross Motor/Fine Motor ☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____				Feeding Date Done: ____/____/____ Results: _____ < 1 year: ☐ Breastfed ☐ Formula ☐ Both ≥ 1 year: ☐ Well-balanced ☐ Needs guidance ☐ Counselled ☐ Referred Dietary Restrictions: ☐ None ☐ Yes (list below)															
Describe Suspected Delay or Concern: _____ Child receives EMT/PE/IEP services: ☐ Yes ☐ No				SCREENING TESTS Date Done: ____/____/____ Results: _____ Metal Lead Level (BLL) _____ ug/dL (required at age 1 yr and 2 yrs and for those at risk) Lead Risk Assessment (annually, age 6 mo-6 yrs): _____ ☐ At risk (for BLL) ☐ Not at risk Hemoglobin or Hematocrit: _____ g/dL _____ % Child Care Only: _____															
IMMUNIZATIONS - DATES DTaP: ____/____/____/____/____/____ Td: ____/____/____/____/____/____ Polio: ____/____/____/____/____/____ Hep B: ____/____/____/____/____/____ Hib: ____/____/____/____/____/____ PCV: ____/____/____/____/____/____ Influenza: ____/____/____/____/____/____ HPV: ____/____/____/____/____/____				Report only positive immunity: IgG Titers Date: _____ Hepatitis B: _____ Measles: _____ Mumps: _____ Rubella: _____ Varicella: _____ Polio 1: _____ Polio 2: _____ Polio 3: _____															
ASSESSMENT ☐ Well Child (200.125) ☐ Diagnoses/Problems (list) _____ ICD-10 Code: _____				RECOMMENDATIONS ☐ Full physical activity ☐ Restrictions (specify) _____ Follow-up Needed: ☐ No ☐ Yes, for _____ Appt. date: ____/____/____ Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision ☐ Other: _____															
Health Care Practitioner Signature _____				Date Form Completed: ____/____/____				DOHMH ONLY: PRACTITIONER ID: _____											
Health Care Practitioner Name and Degree (print) _____				Practitioner License No. and State _____				TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s) Comments: _____											
Facility Name _____				National Provider Identifier (NPI) _____				Date Reviewed: ____/____/____ I.D. NUMBER: _____											
Address: _____ City: _____ State: _____ Zip: _____				REVIEWER: _____															
Telephone: _____ Fax: _____ Email: _____				FORM ID: _____															



Credit Card Payment Authorization Form

Sign and complete this form to authorize Goddard Riverside Community Center @ LSNC to make recurring charges to your credit card listed below. By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for recurring transactions.

Please complete the information below:

I _____ authorize Goddard Riverside Community Center @ Lincoln
(full name)
Square Neighborhood Center to charge my credit card account indicated below for _____
(amount)
on _____ of every month.
(date)

This payment is for _____.
(description of goods/services)

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV _____

SIGNATURE _____

DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.



Credit Card Payment Authorization Form

Sign and complete this form to authorize Goddard Riverside Community Center @ LSNC to charge your credit card listed below. By signing this form you give us permission to debit your account for the amount indicated upon receipt of this form.

This is permission for a one-time transaction.

Please complete the information below:

I _____ authorize Goddard Riverside Community Center @ Lincoln
(full name)
Square Neighborhood Center to charge my credit card account indicated below for _____
(amount)
upon receipt of this form.

This payment is for _____
(description of goods/services)

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV _____

SIGNATURE _____

DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Goddard Riverside

INVESTING IN PEOPLE, STRENGTHENING COMMUNITY

Confirmation of Meals Served

Child's Name: _____

Age: _____

Is enrolled at:

Goddard Riverside at LSNC

(Site Name)

250 W 65th Street

(Site Address)

Start date: _____

(Month/Day/Year)

Directions: Parent/Guardian, write your initials on the line to indicate permission.

As the parent/legal guardian of the child _____, I give permission
by initialing below for the following:

_____ My Child will attend the program: ☐ Monday. ☐ Tuesday. ☐ Wednesday. ☐ Thursday. ☐ Friday

From _____ to _____

(Drop off time)

(Pick up time)

_____ My child will receive ☐ Breakfast ☐ Lunch ☐ Snack ☐ Supper five (5) days per week
(Monday to Fridays) in accordance with CACFP nutrition guidelines, Head Start/Daycare
Food Menus and the food and allergy restrictions set by parent/guardian.

(Date)

(Parent/Guardian Signature)