



Primm ABC Child Care and Preschool  
 4455 South Brandon Street  
 Seattle, Washington 98118  
 Office (206) 723-2038 Fax (206) 760-1704  
 website: Primmabccenter.net  
 Primmabc@Outlook.com

**Child Care Registration**

Date Registered: \_\_\_\_\_ Date Enrolled: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
 Last Name First Middle Nickname

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Street City Zip

Check one: \_\_\_\_\_ One Adult household, employed or in training/school  
 \_\_\_\_\_ Two Adult household, working or in training

Parent/Guardian 1  
 Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

email: \_\_\_\_\_

Monthly Income: \$ \_\_\_\_\_

Days & Hours of Employment \_\_\_\_\_

Names & Ages of other children in home \_\_\_\_\_

If child currently in childcare, Name of center/provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Names, addresses, phone numbers of persons authorized to take child(ren) from Center:

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Cell: \_\_\_\_\_

**EMERGENCY:** In case of an emergency, if parents cannot be reached, contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Zip: \_\_\_\_\_ Cell: \_\_\_\_\_

Hours when care is needed: \_\_\_\_\_ to \_\_\_\_\_

Check days of the week when care is needed:  Monday  Tuesday  Wednesday  Thursday  Friday

Signature of Parent/Guardian

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Developmental, Social, Cultural and Health History**

We want to provide your child with the best care possible. Please help us get to know your child by filling out this questionnaire. Thank You!

**Daily Living Routines**

**Sleeping**

- Please describe your child's usual bedtime routine. \_\_\_\_\_  
\_\_\_\_\_
- Does your child sleep well? \_\_\_\_\_ About how long each night? \_\_\_\_\_ When does child go to bed? \_\_\_\_\_
- Does your child nap? \_\_\_\_\_ How long? \_\_\_\_\_ How many times per day? \_\_\_\_\_
- Does your child sleep with a special blanket or toy? \_\_\_\_\_
- Does your child go to bed with a pacifier? \_\_\_\_\_ Bottle? \_\_\_\_\_
- Does your child have sleep disturbances – nightmares, sleepwalking, waking at night or difficulty going to sleep? \_\_\_ Yes \_\_\_ No

If Yes, please describe \_\_\_\_\_

Do you have any concerns about your child's sleep habits? \_\_\_\_\_

**Eating**

- Would you say your child generally enjoys eating? \_\_\_\_\_
- What are some of your child's favorite foods? \_\_\_\_\_
- Is your child on any special diet? (Please note: State law requires a special form signed by your child's health provider if your child has any diet modifications.)  
\_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_ If so, what \_\_\_\_\_

Are there any foods special to your home or culture that you would like us to offer?  
\_\_\_\_\_

- What does your child use to drink? \_\_\_ Bottle \_\_\_ sippy \_\_\_ regular cup
- If your child uses a bottle, what type of nipple? \_\_\_\_\_
- How does your child eat?  Hands  spoon  fork
- Do you have any concerns or questions about your child's eating? \_\_\_\_\_

**Social**

- What kinds of activities does your child enjoy? (Games, TV, outdoor play, watching others, puzzles, books, playing with model animals, cars, people, bike riding, dancing, music, sports)  
\_\_\_\_\_

How would you describe your child's temperament and personality? (Examples: quiet, shy, moody, intense, cheerful, adaptable, easygoing, fiery, assertive, independent, thoughtful, impulsive, careful)  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

- What is the best way to comfort your child? \_\_\_\_\_  
\_\_\_\_\_
- How do you guide/teach your child correct behavior? \_\_\_\_\_  
\_\_\_\_\_
- Does your child fear certain things? (For example, loud noises, dogs, the dark, clown) \_\_\_\_\_  
\_\_\_\_\_
- Upsetting events, losses (such as separation, divorce or death in the family) and change can affect a child's behavior. We need to be aware of any significant changes in your child's life so we can understand and help her/him cope and adjust. Has anything happened that may affect your child's behavior? \_\_\_\_\_. If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

**Linguistic/Cultural**

- |  |
|--|
| What is your child's first language? _____ Are there other languages? _____  |
| What kinds of family celebrations and cultural events does your child participate in?<br>_____<br>_____                            |
| What kinds of materials and activities would you like to see added to our program that would reflect your child?<br>_____<br>_____ |

- Who lives at home with your child? \_\_\_\_\_
- Do you have any questions or concerns about your child's social and emotional development or behavior? \_\_\_\_\_. If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_
- What can we do to ease your child's adjustment to child care? \_\_\_\_\_  
\_\_\_\_\_
- What would you like to see your child gain/learn at our childcare center? \_\_\_\_\_  
\_\_\_\_\_
- Do you have any questions about our health and safety policies, this questionnaire or anything else?  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

### Morning Routine

- Does your child eat breakfast before coming to child care?  Yes  No
- Can your child dress him/herself? \_\_\_\_\_
- Do you have a morning routine that helps your child prepare for child care? \_\_\_\_\_

(Note: We encourage you to establish a predictable routine of saying goodbye to ease separation. We would be happy to offer some useful suggestions.)

### Toileting

- Does your child use diapers?  Yes  No
- If Yes, what kind?  Disposable  cloth
- If cloth, what type of cover  Plastic pants  diaper wraps
- Is your child potty trained? \_\_\_\_\_
- Does your child use a potty or the toilet? \_\_\_\_\_ Does your child use training pants? \_\_\_\_\_
- How does your child let you know that it's time "to go"? \_\_\_\_\_
- Families tend to use a variety of words to describe bathroom activities. What words does your child use for urine \_\_\_\_\_, bowel movement \_\_\_\_\_, genital area \_\_\_\_\_
- Do you have any questions or concerns about your child's toilet habits? \_\_\_\_\_

(Please note: We are required by State law to send all dirty cotton diapers home unless we have diaper service. We are not permitted to launder diapers on the premises).

### Physical Health

Your child's regular health care provider:

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

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Last physical exam (Mo/Yr): \_\_\_\_\_

Medications: \_\_\_\_\_

Your child's dentist:

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

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Last dental exam (Mo/Yr): \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian



**PRIMM ABC CHILD CARE AND PRESCHOOL  
EMERGENCY CONTACT INFORMATION AND CONSENT FORM**

Child's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Parent/Guardian #1: _____		Relationship: _____	Email: _____
Cell #: _____	Other #: _____	Address: _____	
Parent/Guardian #2: _____		Relationship: _____	Email: _____
Cell #: _____	Other #: _____	Address: _____	

**Emergency Contacts (to be contacted and to whom child may be released if guardian is unavailable):**

Name #1: _____		Relationship: _____	
Cell #: _____	Other #: _____	Address: _____	
Name #2: _____		Relationship: _____	
Cell #: _____	Other #: _____	Address: _____	

**Out-of-State Emergency Contacts (contacts in the event of a natural disaster):**

Name: _____		Name: _____	
Cell #: _____	Other #: _____	Cell #: _____	Other #: _____

**Additional Persons to Whom Child May Be Released:**

Name: _____	Relationship: _____	Cell: _____
Name: _____	Relationship: _____	Cell: _____

**Preferred Sources of Medical Care for Your Child:**

Physician's Name: _____	
Address: _____	Telephone: _____
Dentist's Name: _____	
Address: _____	Telephone: _____
Hospital: _____	
Address: _____	Telephone: _____

**Child's Health Insurance:** Please give type of coverage.

- WA Basic Health Plus     
  CHIP     
  CHP     
  Medicaid (General)  
 Medicaid (Healthy Options) Plan \_\_\_\_\_     
  Private Plan Name \_\_\_\_\_

**Special Conditions, Disabilities, Allergies or Medical Emergency Information:**

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**PARENT/GUARDIAN CONSENT AND AGREEMENT FOR EMERGENCIES:**

As parent/guardian, I consent to have my child receive first aid by facility staff and, if necessary, be transported to receive emergency care. I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above TO ACT IN MY BEHALF until I am available. I agree to review and update this information whenever a change occurs and at least every program year.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## Parent's Agreement

I give consent for my child \_\_\_\_\_ to take part in field trips or excursions under proper supervision.

I further agree that in case of accident or injury, emergency medical care may be given in the event that I cannot be contacted immediately.

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Date**

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## Photo Release

I hereby give consent for the use of photographs and/or video recordings of

\_\_\_\_\_  
for the following educational purposes: Teacher quality improvement, Teacher or program evaluation, and/or public health official guidance. None of these items will be used for marketing or publicity of the center.

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Date**



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## Consent for Health Screening

I give permission for my child (name) \_\_\_\_\_  
(birthdate)\_\_\_\_\_ and (age)\_\_\_\_\_ to receive health promotion screening  
services provided at any child care facility by the Seattle-King County Department  
of Public Health staff, including, but not limited to vision, hearing, dental,  
developmental, speech and behavior. I will be informed of the screening results.  
Department of Public Health staff may discuss screening results with child care  
facility personnel. Consent is also given to contact health care professionals or  
agencies for the purpose of providing or receiving information relative to the  
health care of the above listed child. This consent is effective until revoked in  
writing by the parent/guardian.

Date: \_\_\_\_\_ Signature \_\_\_\_\_

\_\_\_\_\_  
Relationship of legally responsible person to child listed

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Home Phone #

\_\_\_\_\_  
Work Phone #

Name of child care facility: **Primm ABC Center**

\_\_\_\_\_  
Interpreter

\_\_\_\_\_  
Interpreter's agency or relationship to parent



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## Consent to Medical Care and Treatment of Minor Children

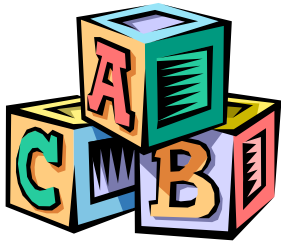
I, \_\_\_\_\_ (the natural parent or legal guardian) hereby give permission that my child, \_\_\_\_\_, may be given emergency treatment to include first aid and CPR by qualified child care staff member at Primm ABC Child Care Center. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by my child's regular physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment.

I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**





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 Sandra Nelson, Executive Director

## Fee and Payment Contract

**Child's Name:** \_\_\_\_\_

**Parent's Name:** \_\_\_\_\_

Check One	Age Group	Monthly Tuition Full Time
<input type="checkbox"/>	<b>Toddlers</b> (12-29 months)	<b>\$2,100</b>
<input type="checkbox"/>	<b>Preschoolers</b> (30 months – 5 years old)	<b>\$1,810</b>
<input type="checkbox"/>	Wraparound child care	<b>\$ 600</b>
<input type="checkbox"/>	<b>School Age (before/after)</b> Up to 12 years old After school - \$675	<b>\$1,200</b>
<input type="checkbox"/>	<b>School Age</b> Summer School	<b>\$1,800</b>

**Registration Fee: \$50** (non-refundable)

**Part-time hours are available as follows:** 8:30 am – 12:30 pm, 12:30 pm – 4:30 pm or up to 3 days attendance weekly. All part-time hours will be charged at the full-time rate.

**Method of Payment:** (please check one)

- Private Pay:** \$ \_\_\_\_\_
- DSHS subsidy:** \$ \_\_\_\_\_      Co-payment:\$ \_\_\_\_\_
- City subsidy:** \$ \_\_\_\_\_      Co-payment:\$ \_\_\_\_\_
- Other subsidy:** \$ \_\_\_\_\_      Co-payment:\$ \_\_\_\_\_

**Payment Agreement:**

I agree to pay tuition  monthly which is due by the 5th of each month Or  
 I will make my payment each month on \_\_\_\_\_.  
 Online and POS transactions are available.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Director Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_