Primm ABC Child Care and Preschool

4455 South Brandon Street
Seattle, Washington 98118
Office (206) 723-2038 Fax (206) 760-1704

www.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	Parent/Guardian 2
Name:_____	Name:_____
Home Address:_____	Home Address:_____
Name of Employer:_____	Name of Employer:_____
Employer Address:_____	Employer Address:_____
Work#:_____ Cell#:_____	Work #:_____ Cell#:_____
email:_____	email_____
Monthly Income: $_____	Monthly Income: $_____
Days & Hours of Employment_____	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?

  _____

  _____

  What kinds of materials and activities would you like to see added to our program that would reflect your child? _____

  _____

- 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 predicable 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:_____

Medications:_____

Your child's dentist:

Name:_____

Address:_____

Phone Number:_____Last dental exam:_____

_____

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:

_____

_____

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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Director, Sandra Nelson

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**

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
☐	**Toddlers** (12-29 months)	**$2,000**
☐	**Preschoolers** (30 months – 5 years old)	**$1,725**
☐	**School Age (before/after)** Up to 12 years old	**$1,100**
☐	**School Age** Summer School	**$1,550**

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:**_____

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