

TACOMA DAY  
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TACOMA, WASHINGTON 98405  
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www.tacomaday.org  
Phone 253-627-5671 FAX 253-627-4513

STUDENT NUMBER \_\_\_\_\_

DATE OF APPLICATION \_\_\_\_\_

DATE OF ENTRY \_\_\_\_\_

DATE WITHDRAWN \_\_\_\_\_

CHILD'S FULL NAME

FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ ALTERNATE # \_\_\_\_\_

PARENTS/GUARDIAN

1<sup>ST</sup> CONTACT

2<sup>ND</sup> CONTACT

NAME \_\_\_\_\_ NAME \_\_\_\_\_

PLACE OF EMPLOYMENT/ADDRESS: \_\_\_\_\_

DEPT. \_\_\_\_\_ DEPT. \_\_\_\_\_

POSITION \_\_\_\_\_ POSITION \_\_\_\_\_

Phone \_\_\_\_\_

E-mail address \_\_\_\_\_ Phone \_\_\_\_\_

HOW DID YOU FIND OUT ABOUT US? \_\_\_\_\_

PLEASE FEEL FREE TO CALL OR DROP IN AT ANY TIME. YOU ARE WELCOME TO PARTICIPATE IN CLASSROOM ACTIVITIES AND FIELD TRIPS.

## PLAN FOR CHILD

The information asked for in this section is meant to assist us in making your child's day run as smoothly as possible.

HOURS CHILD WILL BE AT NURSERY: FROM \_\_\_\_\_ TO \_\_\_\_\_

DAYS OF THE WEEK: M \_\_\_\_\_ T \_\_\_\_\_ W \_\_\_\_\_ TH \_\_\_\_\_ F \_\_\_\_\_

TOILET HABITS; (fill in if necessary for newly toilet trained to feel more comfortable)

BOWEL MOVEMENT – WORD USED \_\_\_\_\_

URINATION – WORD USED \_\_\_\_\_

KIND OF ASSISTANCE NEEDED \_\_\_\_\_

EATING HABITS:

SPECIAL LIKES \_\_\_\_\_

DISLIKES \_\_\_\_\_

ALLERGIES \_\_\_\_\_

SLEEPING HABITS:

NIGHT SLEEP: FROM \_\_\_\_\_ TO \_\_\_\_\_

NAP: YES \_\_\_\_\_ NO \_\_\_\_\_ OR REST \_\_\_\_\_

WHAT TYPES OF ACTIVITIES DOES YOUR CHILD LIKE?

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WHEN YOUR CHILD IS DISTRESSED WHAT COMFORTS HIM/HER?

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PLEASE TELL US WHAT ELSE IS IMPORTANT FOR US TO KNOW ABOUT YOU CHILD?

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**PLAN FOR CHILD CONT.**

**The following questions are very important to Tacoma Day as they will allow us to serve you better and help us to maintain a quality program.**

**IN WHAT WAY/WAYS DO YOU PLAN TO BE INVOLVED IN YOUR CHILD'S PRESCHOOL PROGRAM & WHAT CAN WE DO TO ASSIST YOU?**

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**DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S EDUCATION AND CARE?**

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**WHAT GOALS FOR YOUR CHILD CAN WE HELP YOU WITH?**

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**Parents are always welcome at Tacoma Day. If you have any time you would like to volunteer let us know. You are a valuable part of your child's education.**

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**FEE INFORMATION**

FEE \_\_\_\_\_ DATE \_\_\_\_\_

**Please note Tacoma Day does not discount days for vacations. Days not used do not carry over to the next month. A full day of care is 10 hours, WA State regulations. Please meet with the office if you need to make arrangements with us that are agreeable with the state. Tacoma Day requires a 10 day notice for slot termination.**

**CARE IS TO BE PAID IN ADVANCE BEFORE THE 5<sup>TH</sup> OF EACH MONTH!**

I AGREE TO KEEP MY APPLICATION FORM UP-TO-DATE REPORTING TO THE OFFICE CHANGES IN INFORMATION REQUIRED BY TACOMA DAY CARE AND PRESCHOOL ASSOCIATION.

I HAVE RECEIVED A COPY OF THE PARENTS HANDBOOK.

I AGREE TO COMPLY TO THE POLICIES OF TACOMA DAY CARE AND PRESCHOOL ASSOCIATION AS SET FORTH IN THE PARENTS HANDBOOK.

IF I AM UNHAPPY WITH THE CARE GIVEN TO MY CHILD OR HAVE CONCERNS ABOUT THE CENTER I WILL SHARE THESE CONCERNS WITH THE DIRECTOR. I FURTHER UNDERSTAND THAT I MAY CONTACT THE CENTER 5 LICENSOR AT 597-4567.

\_\_\_\_\_  
PARENT(S) SIGNATURE

\_\_\_\_\_  
DATE

TACOMA DAY CARE & PRESCHOOL ASSOCIATION RECEIVES FUNDING FROM UNITED WAY, THE CHILD AND ADULT FOOD PROGRAM AND GRANTS FROM FOUNDATIONS. THESE SOURCES ENABLE TDCPA TO OFFER A QUALITY PROGRAM AT AN AFFORDABLE COST. IN ORDER FOR TDCPA TO QUALIFY FOR THESE FUNDS, GATHERING CERTAIN INFORMATION FROM OUR FAMILIES IS VITAL. THIS DATA SERVES A VERY IMPORTANT FUNCTION. IT GIVES OUR FUNDERS A PICTURE OF OUR SERVICES AND INFORMATION CONCERNING NOT ONLY OUR FUTURE NEEDS BUT THE FUTURE NEEDS OF THE COMMUNITY AS WELL.

PUT ONE CHECK MARK FOR EACH CHILD

1. SEX OF CHILD/CHILDREN ENROLLED: MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

2. CHILD/CHILDREN ENROLLED RACIAL/ETHNIC CATEGORY:

**NON-HISPANIC Ethnicity**

**HISPANIC Ethnicity**

\_\_\_\_\_ AMERICAN INDIAN OR ALASKA NATIVE

\_\_\_\_\_ AMERICAN OR ALASKAN NATIVE

\_\_\_\_\_ ASIAN

\_\_\_\_\_ ASIAN

\_\_\_\_\_ BLACK /African American

\_\_\_\_\_ BLACK/African American

\_\_\_\_\_ Native Hawaiian other Pacific Islander

\_\_\_\_\_ Native Hawaiian other Pacific Islander

\_\_\_\_\_ WHITE/Caucasian

\_\_\_\_\_ WHITE/ Caucasian

Multi-Racial please indicate \_\_\_\_\_

Multi-Racial please indicate \_\_\_\_\_

\_\_\_\_\_ UNKNOWN

\_\_\_\_\_ UNKNOWN

3. PHYSICAL OR DEVELOPMENTAL HANDI CAP? YES \_\_\_\_\_ NO \_\_\_\_\_

4. TOTAL YEARLY GROSS INCOME OF FAMILY \$ \_\_\_\_\_

5. PARENT/PARENTS ARE: WORKING \_\_\_\_\_ GOING TO SCHOOL \_\_\_\_\_ OTHER \_\_\_\_\_  
(or legal guardian) (specify)

6. FAMILY SIZE (CHILDREN & PARENTS) \_\_\_\_\_

7. SINGLE PARENT HOUSEHOLD \_\_\_\_\_ TWO PARENT HOUSEHOLD \_\_\_\_\_

8. MILITARY DEPENDENT (CHILD) \_\_\_\_\_

9. ZIP CODE \_\_\_\_\_

10. PLEASE INDICATE PARENT/PARENTS AGE RANCE:

16-19 \_\_\_\_\_ 26-30 \_\_\_\_\_ 36+ \_\_\_\_\_

20-25 \_\_\_\_\_ 31-35 \_\_\_\_\_

11. IF YOU ARE NOT A PARENT BUT A LEGAL GUARDIAN PLEASE INDICATE:

FOSTER PARENT \_\_\_\_\_ GRANDPARENT \_\_\_\_\_ OTHER \_\_\_\_\_

**CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT**

I HERBY GRANT PERMISSION TO TACOMA DAY CARE & PRESCHOOL ASSOCIATION TO  
SEEK MEDICAL ATTENTION FOR MY CHILD \_\_\_\_\_

IN THE EVENT SUCH TREATMENT IS DEEMED NECESSARY, AND I AM UNABLE TO BE  
CONTACTED. I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO CONTACT ME  
PRIOR TO ANY TREATMENT ADMINISTERED TO MY CHILD.

I FURTHER CONSENT TO MEDICAL OR SURGICAL TREATMENT BY ANY LICENSED  
PHYSICIAN AND OR HOSPITAL AND FURTHER CONSENT TO ADMINISTRATION OF  
NECESSARY ANESTHETICS, MEDICAL TREATMENT, TESTS, TRANSFUSIONS,  
INJECTIONS, OR DRUGS AND THE PERFORMING OF WHATEVER OPERATION MAY BE  
DEEMED NECESSARY OR ADVISABLE WHILE UNDER CARE. FUTHERMORE, I GRANT  
PERMISSION FOR THE EXECUTIVE DIRECTOR OR DESIGNEE TO CONTACT 911 FOR  
ASSISTANCE AND/OR TRANSPORTATION FOR MY CHILD IN THE EVENT IT IS  
NECESSARY FOR MEDICAL ATTENTION.

CHILD'S BIRTH DATE \_\_\_\_\_ (MONTH, DAY, YEAR)

CHILD'S PHYSICIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

CHILD'S DENTIST \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

DATE OF LAST PHYSICAL \_\_\_\_\_ DATE OF LAST TETANUS/DTP \_\_\_\_\_

CHILD HAS A **HEALTH PLAN** IN PLACE FOR: \_\_\_\_\_

\_\_\_\_\_  
(SEE ATTACHED)

MEDICAL INSURANCE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

GROUP # \_\_\_\_\_ MEMBERSHIP # \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PARENTS/LEGAL GUARDIAN

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
HOME PHONE

\_\_\_\_\_  
WORK PHONE

**EMERGENCY INFORMATION**

PLEASE LIST PEOPLE TO CONTACT IN THE EVENT OF AN EMERGENCY AND WE ARE UNABLE TO REACH YOU. WE ASK THAT YOU KEEP THIS LIST CURRENT AND THAT THE PEOPLE YOU CHOOSE KNOW THAT THEY COULD BE USED AS AN EMERGENCY CONTACT BY US. PLEASE NOTE THAT ALTHOUGH THESE PEOPLE ARE LISTED AS YOUR EMERGENCY CONTACTS YOU STILL HAVE TO NOTIFY US IF YOU WOULD BE SENDING THEM TO PICK UP YOUR CHILD. WE ARE RESPONSIBLE FOR YOUR CHILD WHILE THEY ARE IN OUR CARE AND CANNOT JUST RELEASE THEM AT ANYTIME WITHOUT A PHONE CALL OR WRITTEN PERMISSION FROM YOU ON YOUR CHILD'S SIGN-IN & OUT SHEET.

| NAME     | ADDRESS | Email/PHONE |
|----------|---------|-------------|
| 1. _____ | _____   | _____       |
| 2. _____ | _____   | _____       |
| 3. _____ | _____   | _____       |

VISITING RIGHTS ARE DENIED TO \_\_\_\_\_

WHILE TDCPA NEVER ALLOWS ANYONE TO VISIT OR TAKE THE CHILD FROM THE PREMISES WITHOUT PARENTAL NOTIFICATION IT IS IMPORTANT FOR US TO BE AWARE IF THERE ARE VISITING RIGHTS DENIED TO ANYONE. IF YOU HAVE A COURT ORDER MAKE A COPY FOR OUR FILES. THIS ALLOWS US TO CALL FOR POLICE BACK-UP.

MAY YOUR CHILD APPEAR IN CLASSROOM ACTIVITY PICTURES/FILMS? \_\_\_\_\_

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HEALTH CONCERNS ? PLEASE CIRCLE

RESPIRATORY (Asthma, RSV, RAD, other)      DIABETES      SEIZURES

CHRONIC CONDITIONS (diagnosed or in progress, IEP? need copy with enrollment)

FOOD ALLERGIES      NON-FOOD ALLERGY      HEART CONDITION

DOES YOUR CHILD TAKE ANY MEDICATION ON A REGULAR BASIS OR FOR EMERGENCIES? \_\_\_\_\_

REASON: \_\_\_\_\_

**PLEASE NOTE IF ANY OF THE ABOVE IS INDICATED WE WILL NEED TO HAVE A COMPLETED HEALTH PLAN IN PLACE BEFORE YOUR CHILD CAN ATTEND.**

ARE THERE ANY FOODS YOUR CHILD MAY NOT EAT FOR CULTURAL, ETHNIC OR RELIGIOUS REASONS? \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

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

|    | NAME  | ADDRESS | PHONE |
|----|-------|---------|-------|
| 1. | _____ | _____   | _____ |
|    | MOM   |         |       |
| 2. | _____ | _____   | _____ |
|    | DAD   |         |       |
| 3. | _____ | _____   | _____ |
| 4. | _____ | _____   | _____ |
| 5. | _____ | _____   | _____ |

SPECIAL INFORMATION:

Please note that the purpose of this document is for keeping current emergency numbers so that in the event of a major occurrence that would displace us from the building we can get in touch with you in a timely manner. **PLEASE NOTE THAT ALTHOUGH THESE PEOPLE ARE LISTED AS YOUR EMERGENCY CONTACTS YOU STILL HAVE TO NOTIFY US IF YOU WOULD BE SENDING THEM TO PICK UP YOUR CHILD. WE ARE RESPONSIBLE FOR YOUR CHILD WHILE THEY ARE IN OUR CARE AND CANNOT JUST RELEASE THEM AT ANYTIME WITHOUT A PHONE CALL OR WRITTEN PERMISSION FROM YOU ON YOUR CHILD'S SIGN-IN & OUT SHEET.**