Washington State Department of CHILDREN, YOUTH & FAMILIES

KENNEWICK SCHOOL DISTRICT ECEAP

ENROLLMENT 2023-2024

ECEAP ELIGIBILITY CRITERIA

Please use pen to fill out application

Children are eligible for ECEAP if they are at least three years old, but not five years old by August 31st of the school year and live within the Kennewick School District boundaries.

THE FOLLOWING INFORMATION IS NEEDED FOR ENROLLMENT & ELIGIBILITY:

1. Income verification from previous year stating amounts, all that apply. **(If applicable)**:

   - Tax Return (1040) or IRS Transcript or W-2s or Pay Stubs for 12 months
   - Unemployment Letter
   - Child Support Received (**ONLY** required if legally-binding by court order)
   - DSHS TANF/Foster Care Grant
   - Disability Income, Including SSI
   - Self-Employment Income
   - Worker's Compensation (L&I**)**
   - Tribal Income **(**taxable)
   - Any other income not listed above

2. Immunizations of the child (ren) you are registering. **MUST BE COMPLETE.**

3. Birth certificate of the child (ren) being registered / **Proof of Age**.

4. Proof of legal guardianship/authority to enroll a child (**If not biological parent or no birth certificate available).**

5. Address verification of residential status. **Please bring PUD bill or rental/lease agreement**.

6. Provider One Card/Private Insurance Card.

7. Parenting Plan/Foster Care –Certified or signed by Judge (**if applicable**).

8. Child's IEP-Individualized Education Plan **(if applicable**).

To enroll or for more information contact:
Nadia Klinginsmith, ECEAP Secretary
Email: nadia.klinginsmith@ksd.org
123 S Kent St. **Portable 4**
Kennewick, WA 99336
Phone: 509-222-5027
Fax: 509-222-5037

Washington State Department of CHILDREN, YOUTH & FAMILIES

2023-2024 ECEAP Prescreen & Application

Return to: Kennewick ECEAP Office
123 S Kent St. Portable 4 Kennewick, WA. 99336
Ph: (509) 222-5027 Fax: (509)222-5037

KENNEWICK SCHOOL DISTRICT ECEAP

Preferred Classroom Session:

- ☐ AM Session 8:20 am to 11:20 am
- ☐ Full School Day - **4-Year-olds ONLY** 8:20 am to 3:35 pm
- ☐ PM Session 12:35 am to 3:35 pm
- ☐ Dual Full School Day - **4-Year-olds ONLY** 8:20 am to 3:35 pm

Section 1: Child Information

Legal First Name | Middle Name | Legal Last Name

Child Date of Birth: _____ Nick Name: _____ Gender Identity: _____

Tribal Nation- Is this child a member of a tribal nation? ☐ Yes ☐ No

IEP - Is this child on an Individualized Education Program (IEP)? ☐ Yes ☐ No

Child was determined eligible for special education services through evaluation by a School district or tribal school, but parent/ guardian declined services ☐ Yes ☐ No

CPS - Is this child's family actively involved in and/or receiving support from Tribal or State Systems including Child Protective Services (CPS), Family Assessment Response (FAR), Indian Child Welfare (ICW), comparable triable services or Law Enforcement/court system regarding child abuse, neglect, or sexual assault? ☐ Yes ☐ No

Foster Care - Is this child in official foster care? *This means there is a caregiver authorization from a state or tribe that says this is a foster care placement* ☐ Yes ☐ No

Kinship - Is this child in kinship care with a relative or suitable other, with or without a grant? ☐ Yes ☐ No

Adopted after foster/kinship care - Was this child adopted after foster care, kinship care, or after living in an orphanage in another country (*This does not include other adoptions*)? ☐ Yes ☐ No

Housing (select one)

- ☐ Rent or own an adequate residence
- ☐ Doubled-up with another family for convenience, choosing to be close to family or friends, or choosing to safe for future plans
- ☐ Doubled-up with another family due to loss of housing, economic hardship, or a similar reason
- ☐ In an emergency or transitional shelter
- ☐ Sleeping in a hotel, motel, car, park, campsite, or similar location
- ☐ Moving from place to place (couch surfing)
- ☐ Inadequate housing such as no water, heat or electricity, excessive mold, or no cooking facilities

Language This child speaks (select one)

- ☐ Only English
- ☐ Mostly English, and some of another home language
- ☐ Some English, but mostly another home language
- ☐ English and another language at age level (bilingual)
- ☐ Only a home language other than English

Child's first language: _____

Child's second language: _____

Is this child Hispanic/Latino? ☐ Yes ☐ No

- ☐ Argentinian
- ☐ Bolivian
- ☐ Chilean
- ☐ Colombian
- ☐ Costa Rican
- ☐ Cuban
- ☐ Dominican
- ☐ Ecuatorian (Ecuadorian)
- ☐ Guatemalan
- ☐ Honduran
- ☐ Mexican or Mexican-American (Chicano)
- ☐ Nicaraguan
- ☐ Panamanian
- ☐ Peruvian
- ☐ Puerto Rican
- ☐ Salvadoran
- ☐ Spanish
- ☐ Uruguayan
- ☐ Venezuelan
- ☐ Latin American
- ☐ Other *Hispanic or Latino*

_____

What race(s) do you consider this child? *(Check all that apply)*

- ☐ **White**
- ☐ **Black or African American**
- ☐ **Alaska Native**
  - ☐ Aleut (Unangan)
  - ☐ Alutiiq
  - ☐ Athabaskan
  - ☐ Eskimo (Inupiaq or Yupik)
  - ☐ Eyak
  - ☐ Haida
  - ☐ Tlingit
  - ☐ Tsimshian
  - ☐ Other Alaska Native

_____

- ☐ **Asian**
  - ☐ Asian Indian
  - ☐ Bangladeshi
  - ☐ Bhutanese
  - ☐ Burmese
  - ☐ Cambodian/ Kampuchean
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Hmong
  - ☐ Indonesian
  - ☐ Japanese
  - ☐ Korean
  - ☐ Laotian
  - ☐ Madagascar
  - ☐ Malayan
  - ☐ Maldivian
  - ☐ Mongolian
  - ☐ Nepali
  - ☐ Pakistani
  - ☐ Singaporean
  - ☐ Sri Lankan
  - ☐ Taiwanese
  - ☐ Thai
  - ☐ Vietnamese
  - ☐ Other Asian

_____

- ☐ **American Indian**
  - ☐ Chehalis
  - ☐ Chinook
  - ☐ Colville
  - ☐ Cowlitz
  - ☐ Duwamish
  - ☐ Hoh
  - ☐ Jamestown
  - ☐ Kalispel
  - ☐ Kikiallus
  - ☐ Lower Elwha
  - ☐ Lummi
  - ☐ Makah
  - ☐ Muckleshoot
  - ☐ Nisqually
  - ☐ Nooksack
  - ☐ Port Gamble Klallam
  - ☐ Puyallup
  - ☐ Quileute
  - ☐ Quinault
  - ☐ Samish
  - ☐ Sauk-Suiattle
  - ☐ Shoalwater
  - ☐ Skokomish
  - ☐ Snohomish
  - ☐ Snoqualmie
  - ☐ Snoqualmoo
  - ☐ Spokane
  - ☐ Squaxin Island
  - ☐ Steilacoom
  - ☐ Stillaguamish
  - ☐ Suquamish
  - ☐ Swinomish
  - ☐ Tulalip
  - ☐ Upper Skagit
  - ☐ Yakama
  - ☐ Other American Indian

_____

- ☐ **Native Hawaiian or Other Pacific Islander**
  - ☐ Fijian
  - ☐ Guamanian
  - ☐ Kosraean
  - ☐ Mariana Islander
  - ☐ Marshall Islander
  - ☐ Melanesian
  - ☐ Micronesian
  - ☐ Native Hawaiian
  - ☐ Palauan
  - ☐ Papua New Guinean
  - ☐ Ponapean (Pohnpeian)
  - ☐ Samoan
  - ☐ Solomon Islander
  - ☐ Tahitian
  - ☐ Tarawa Islander
  - ☐ Tokelauan
  - ☐ Tongan
  - ☐ Trukese (Chuukese)
  - ☐ Vanuatuan/New Hebrides
  - ☐ Yapese
  - ☐ Other Pacific Islander

_____

Section 2: Household Members

Please list everyone living in the household who may be counted in family size.

For families temporarily living with relatives or others, do not list the hosts.

For families with two households when there is joint custody with no primary parent and no child support:

- Enter the household members for both households in the graph below.
- Mark members of the second household.
- Then, answer the questions about financial support and relationships.
  - ❖ ***Staff will use this information to calculate family size to determine State Median Income (SMI).***

First Name	Last Name	Birthdate	Relationship to ECEAP Child	Does the ECEAP child's parent or guardian financially support this person?* *See note below for people age 19 or older.*	Is this person related to the ECEAP child's parent/guardian by blood, marriage, or adoption?
ECEAP Child:			ECEAP Child	Yes	Yes
Parent/Guardian:				Yes	Yes
Parent/Guardian:				Yes	Yes

**Answer No for a person age 19 or older who has earned or unearned income that covers more than half of their expenses. Answer Yes if the ECEAP child's parents pay more than half of their expenses.*

For staff use only (DO NOT FILL THIS OUT):
Family size for SMI chart _____

For children in foster care, kinship, or adopted after foster/kinship care or living in an orphanage in another country, count family size as 1. For all others, count people YES for both questions above.

Section 3: Primary Family Contact Information				
Contact Name 1:	Relationship to Child:			
Parent/Guardian's Birth Date:	Do you need an interpreter to communicate with English speakers? ☐ Yes ☐ No If yes, what language(s) do you speak?			
Physical Address	Apt Number	City	State	Zip
Mailing Address *(if different than physical address)*	Apt Number	City	State	Zip
Email	Phone	Alternate Phone		
Contact Name 2:	Relationship to Child:			
Parent/Guardian's Birth Date:	Phone:			
Email:	Alternate Phone:			

Section 4: Child lives with

☐ One parent/guardian (Name): _____ ***Skip to section 5***

☐ Two parents/guardians in same household (Names):

_____ _____

☐ Two parents/guardians in two households (50/50 Custody)

If this is checked, answer these questions to determine which parents' income is counted for ECEAP eligibility.

Does one household have primary legal custody? ☐ Yes ☐ No

If **yes**, which parent has primary custody? _____

Spouse of this parent, if any _____ ***Skip to section 5***

If **no**, ECEAP will count the income from the legal parent/guardian for each household. Do not include their spouses. Enter the legal parents' names here:

Household 2:	Relationship to Child:			
Parent/Guardian's Birth Date:	Do you need an interpreter to communicate with English speakers? ☐ Yes ☐ No If yes, what language(s) do you speak?			
Physical Address	Apt Number	City	State	Zip
Mailing Address *(if different than physical address)*	Apt Number	City	State	Zip
Email	Phone	Alternate Phone		

Section 5: Parent Employment, Training, and Other Activities

Answer the following questions for each parent/guardian listed in question #3.

Do not count the same hours in more than one category. For example:

- Do not count the same hours of the week in both employment and WorkFirst.
- Do not count the same CPS childcare hours separately for two parents

	Parent/Guardian #1 **Name**:	Parent/Guardian #2 **Name:**
Employed?	☐ Yes ☐ No	☐ Yes ☐ No
a. If yes, average paid hours per week		
b. If yes, enter employer name (don't enter unknown or N/A)		
c. If yes, enter employer phone number or email		
In school or job training?	☐ Yes ☐ No	☐ Yes ☐ No
a. If yes, class hours per week		
b. If yes, study hours per week (maximum 10)		
c. If yes, enter name of school or training organization.		
d. If yes, enter goal or major.		
Travel between childcare and work/school?	☐ Yes ☐ No	☐ Yes ☐ No
a. If yes, hours per week (maximum 10)		
CPS/FAR/ICW childcare hours not counted above?	☐ Yes ☐ No	☐ Yes ☐ No
a. Additional hours per week of childcare approved by CPS		
Approved WorkFirst hours not counted above?	☐ Yes ☐ No	☐ Yes ☐ No
a. If yes, name of activity.		
b. If yes, total hours per week		
Disabled parent unable to work and unable to care for the child while the other parent works?	☐ Yes ☐ No	☐ Yes ☐ No
If either parent has more than 55 hours total per week, explain:		

Section 6: How did you find out about ECEAP

☐ DCYF website ☐ Community event ☐ Flyer ☐ ECEAP employee ☐ Word of mouth

☐ Caseworker ☐ Media ☐ Community agency- Name of agency:_____

☐ Other

Section 7: Survey for Statewide Planning

If you could choose the length of day for your child's preschool, which is best for your child and family?

Please note, these options may not all be available in your community this year.

☐ Part Day – about three hours, three or four days a week.

☐ School Day – about six hours, four or five days a week.

☐ Working Day – available all day, all year, like a childcare center.

Section 8: Household Situation

- Does your household receive subsidized housing, such as a housing voucher or cash assistance for housing?
  ☐ Yes ☐ No
- Does your household currently receive a Working Connections childcare subsidy for this child?
  ☐ Yes ☐ No

Section 9: Income Received by Child's Parent(s) or Guardian(s)

For children in foster care, kinship care, or adopted after foster or kinship care, fill in this box and *skip to Section*

- Monthly grant or payment for foster care, kinship care, or adoption support $ _____
- Number of children covered by this grant or payment _____
- Case number or Client ID number, if any: _____
- Payment source (check): ☐ DSHS ☐ SSI ☐ Tribe ☐ Other _____

Did your household receive income during the last calendar year or during the previous 12 months? ☐ Yes ☐ No

If no, provide the reason there is no income and explain how basic needs are met:

Check all forms of income that apply below.

CHECK BOX	INCOME TYPE
☐	Income from Employment
☐	Child Support received, if required by a child support order
☐	Disability income, including SSI
☐	Military Leave & Earnings Statement (LES). Count all pay and allowances except BAH, BAS, FSH, and HFP/IDP.
☐	Self-employment net income
☐	Social Security or other retirement benefits
☐	State or Tribal TANF Grants
☐	Unemployment
☐	Workers Compensation (L&I)
☐	Tribal income (taxable)
☐	Emergency Assistance Cash Payments
☐	Insurance Payments that are regular, not 1 time
☐	Retirement or pension plans
☐	Training Stipend
☐	Scholarship, Grants, or Fellowships for living expenses
☐ **Subtract**	Child support paid to another household, if required by a legally binding child support order

Do you still receive the income above? ☐ Yes ☐ No ***If yes, skip to section 10.***
If no, and your current circumstances have recently changed, please explain:

_____

☐ Loss of wage earner ☐ Divorce or separation ☐ Unplanned loss ☐ Reduced work hours
☐ Health/Injury ☐ Loss of benefits ☐ Similar unexpected circumstance (explain)
☐ Job Loss – lack of access or ability to afford childcare for newborn _____

What is your monthly income? _____ For which month? _____

Section 10: Previous Enrollment

This child was previously enrolled in:

☐ Head Start at your agency
☐ Migrant/Seasonal Head Start anywhere in WA
☐ Early Head Start
Name if EHS Grantee: _____
☐ Any birth to three home visiting program and toddler
☐ Early ECEAP
Name if Early ECEAP contractor:
_____

☐ ECLIPSE
ESIT- Early Support of Infants
Name of ESIT Provider:
_____

☐ Part C IDEA Early Intervention program in another state
Name of the state and provider:
_____

Section 11: IEP or Suspected Delay

☐ This child has an Individualized Education Program (IEP).
☐ This child was determined eligible for special education services through evaluation by a school district or tribal school, but parent/guardian declined services.
☐ This child has a diagnosed developmental delay or disability with no IEP.
☐ This child completed a developmental screening that recommended referral for further evaluation.
☐ This child has a suspected developmental delay or disability.
(*No IEP, diagnosis, or screening, or completed developmental screening with result, "rescreen needed".)*
Please Describe:

❖ *If this child has an IEP check all categories of the IEP.* ***If not skip to Section 12.***

☐ Autism
☐ Deaf-blindness
☐ Developmental delay
☐ Emotional disturbance
☐ Hearing impairment
☐ Intellectual disability
☐ Multiple disabilities
☐ Orthopedic impairment
☐ Other health impairment
☐ Specific learning disability
☐ Speech or language impairment
☐ Traumatic brain injury
☐ Visual impairment

IEP Start Date: _____ IEP End Date: _____
What school district issued this child's IEP? _____

This child will receive IEP services:

☐ Within the ECEAP classroom only
☐ During ECEAP hours only, but outside the ECEAP classroom
☐ Outside ECEAP hours

Section 12:

Has this child been expelled from any early learning program or childcare due to behavior? ☐ Yes ☐ No

ECEAP serves children with behavior issues. ***Checking yes will not exclude your child.***

Section 13: Additional Questions				
We use this information to choose the children who most need ECEAP. All responses will be kept confidential.				
Does this child have a household family member who has a chronic physical or mental health condition that: (*if yes select one*) • Severely impacts their ability to engage in work, school, or family life?	☐	Yes	☐	No
• Moderately impacts their ability to engage in work, school, or family life?	☐	Yes	☐	No
Does this child have a parent who was under age 18 when this child was born?	☐	Yes	☐	No
Does this child have a parent who: (if yes select one) • is a migrant or seasonal agricultural worker? (*51% or more of family income from agricultural work)*	☐	Yes	☐	No
• Moves with child to engage in traditional cultural practices or employment (seasonal or temporary in agricultural or fishing work)?	☐	Yes	☐	No
Does this child have a parent currently on active duty in the U.S. Military?	☐	Yes	☐	No
Does this child have a parent currently a member of a National Guard unit or a Military Reserve unit?	☐	Yes	☐	No
Does this child have a military parent deployed currently, or within the past 12 months, or for a total of 19 or more months within the child's lifetime?	☐	Yes	☐	No
Does this child have a family who attended an Indian boarding school?	☐	Yes	☐	No
Does this child have a parent who is incarcerated in jail, prison, or a detention center?	☐	Yes	☐	No
Has this child experienced the loss of a parent or primary caregiver, such as by death, abandonment, or deportation	☐	Yes	☐	No
Has this child experienced the divorce or separation of their parents?	☐	Yes	☐	No
Has this child experienced homelessness within the last 12 months?	☐	Yes	☐	No
Has this child lived in a household with domestic violence, including in-utero?	☐	Yes	☐	No
Has this child lived in a household with substance abuse, including in-utero?	☐	Yes	☐	No
Has this family previously received support or been involved in tribal or state systems including CPS/FAR/ICW services, or comparable tribal service, or been involved with law enforcement/court system regarding child abuse, neglect, or sexual assault?	☐	Yes	☐	No
Has this child been reunited with parents after foster or kinship care in the past 12 months?	☐	Yes	☐	No
ECEAP received a professional referral for this family.	☐	Yes	☐	No
If yes, which agency made the referral?				

Section 14: Parent Education Level – Check all that apply

Highest level of education	Parent/Guardian 1 Name _____	Parent/Guardian 2 Name _____
6th grade or less	☐	☐
7th to 12th grade, no diploma or GED	☐	☐
High school diploma or GED	☐	☐
Some college	☐	☐
Professional certificate (vocational schools)	☐	☐
Associate Degree	☐	☐

Bachelor's degree	☐	☐
Master's degree or doctorate	☐	☐

Section 15: Health Information - *Please attach a copy of the child's immunization record*

Does this child have a chronic physical or mental health condition that: ☐ Yes ☐ No ☐ Unknown

- Severely impacts child development or attendance?
- Moderately impacts child development or attendance? ☐ Yes ☐ No ☐ Unknown

❖ If yes, please describe:

Was this child born preterm (less than 37 weeks), or weigh less than 5.5 pounds at birth? ☐ Yes ☐ No ☐ Unknown

Does this child have medical insurance or coverage? ☐ Yes ☐ No ☐ Unknown

☐ Washington Apple Health for Kids/ Provider One Services Card

☐ Military Coverage ☐ Private Medical Insurance ☐ Tribal Coverage

Does this child have a regular doctor or medical clinic? ☐ Yes ☐ No ☐ Unknown

- Name of clinic or provider: _____ Phone: _____
- Name of medical professional: _____

Did this child have a well-child exam within the last 12 months? ☐ Yes ☐ No ☐ Unknown

❖ Date of last well-child exam before applying for ECEAP: ☐ Date Unknown

Does this child have dental insurance or coverage? ☐ Yes ☐ No ☐ Unknown

☐ Washington Apple Health for Kids/ Provider One Services Card

☐ Military Coverage ☐ Private Dental Insurance ☐ Tribal Coverage

☐ ABCD (not available in all countries)

Does this child have a regular doctor or dental clinic? ☐ Yes ☐ No ☐ Unknown

- Name of clinic or provider: _____ Phone: _____
- Name of dental professional: _____

Did this child have a dental screening within the last 6 months? ☐ Yes ☐ No ☐ Unknown

❖ Date of last dental screening before applying for ECEAP: ☐ Date Unknown

Signature of Parent/Guardian

I promise that the information on this form is true and correct. I have reported all my income and family size, as required by ECEAP. If I knowingly provide false information, I understand my family may be unable to continue ECEAP services. Additionally, I may have to repay the amount spent on my child's ECEAP.

I understand that information from this application is entered in the Early Learning Management System (ELMS) operated by the Department of Children, Youth, and Families (DCYF). DCYF is committed to protecting confidential and personal information that could identify a child or family. No information related to immigration status is entered into ELMS or shared with state or federal agencies. Information in ELMS may be used for:

- Research studies to determine if participating in ECEAP helps children later in life.
- To prove Washington State spends some of their own dollars on programs for families, which is required to receive Temporary Assistance for Needy Families dollars from the federal government.

Print Name _____

Signature _____ Date _____

Print Name _____

Signature _____ Date _____

Signature of ECEAP Staff Member who verified eligibility

I certify that, to the best of my knowledge, the information on this form is true and correct. I viewed and verified documentation establishing this child's eligibility for ECEAP. I understand that ECEAP Performance Standards require that I notify the Department of Children, Youth, and Families if I suspect any fraudulent use of ECEAP funds including, but not limited to, an employee intentionally entering deceptive or false information into ELMS regarding:

- Child eligibility criteria.
- Children's actual start dates and last days in class.
- Class start or end dates.
- Services that were not actually provided.
- A family providing false information in order to enroll in ECEAP.

Print Name _____

Title _____

Signature _____ Date _____

Washington State Department of CHILDREN, YOUTH & FAMILIES

EMERGENCY & PERMISSION FOR SERVICES

KENNEWICK ECEAP

KENNEWICK SCHOOL DISTRICT ECEAP

CHILD'S NAME _____ DATE OF BIRTH _____
ADDRESS _____ CHILD CARE ☐ YES ☐ NO
CHILD CARE PROVIDER _____ PHONE NUMBER _____
RESTRAINING ORDER/PARENTING PLAN ON FILE: ☐ YES ☐ NO

PARENT/GUARDIAN CONTACT INFORMATION

FATHER/GUARDIAN _____ HOME PHONE _____ CELL _____
PLACE OF WORK _____ WORKPHONE _____

MOTHER/GUARDIAN _____ HOME PHONE _____ CELL _____
PLACE OF WORK _____ WORKPHONE _____

EMERGENCY CONTACT INFORMATION (please list at least one contact)

NAME _____ RELATIONSHIP _____ PHONE _____
NAME _____ RELATIONSHIP _____ PHONE _____

EMERGENCY MEDICAL TREATMENT AND INSURANCE AUTHORIZATION

As the parent/guardian of the above named student, my signature on this form authorizes any emergency medical treatment by a licensed medical physician and/or medical facility in the event of an accident, illness or injury.
Does the supervising person have your permission to seek medical attention from the nearest licensed physician and/or medical facility?
☐ YES ☐ NO

ALLERGIES ☐ YES ☐ NO TYPE OF ALLERGY/REACTION _____
ANY SPECIFIC INSTRUCTIONS NECESSARY FOR TREATMENT _____
SPECIAL HEALTH/HANDICAP PROBLEMS _____

Medical Home/Doctor: _____ **Dental Home/Dentist:** _____
Preferred Hospital: ☐ Trios ☐ Kadlec ☐ Lourdes

I GIVE PERMISSION FOR MY CHILD TO

1. Be transferred in district vehicles and staff vehicles for ECEAP activities ☐ YES ☐ NO
2. Receive first aid treatment of minor injuries by ECEAP staff ☐ YES ☐ NO
3. Receive emergency medical treatment, including surgery from physicians, dentists, R.N.s, or other workers; including transportation ☐ YES ☐ NO
4. Have copies of health summary and immunization records sent to the School District where child will be attending next year according to district policy ☐ YES ☐ NO

I GIVE ECEAP STAFF PERMISSION TO

5. Take my child's picture to be used in classroom activities (i.e. picture by coat hooks) ☐ YES ☐ NO
6. Take my child's picture/video or use children's artwork, quotations and information for ECEAP publicity and for information sharing (i.e. parent meetings, workshops) without restrictions unless listed below. I waive any claim to payment of any sort for the use of pictures/videos. ☐ YES ☐ NO

SIGNATURE _____ DATE _____

Washington State Department of CHILDREN, YOUTH & FAMILIES

KENNEWICK SCHOOL DISTRICT ECEAP

Bussing/Classroom Authorization Adult Contact Form
AUTORIZACIÓN DE SALÓN DE CLASE Y ACERCA DEL AUTOBÚS

Child's Name/ *Nombre del niño(a)*: _____

Parent(s) name(s)/ *Nombre de los padres*: _____

Phone No/ *Número de teléfono*: _____

Adults (16 and over) who are authorized to pick my child up from school and bus stop.
Adultos (16 años de edad o mayor) que están autorizados de recoger al su estudiante de la escuela o parada del autobús.

Name/ *Nombre*	**Relationship/ *Relación***	**Phone Number/ *Número telefónico***

Proof of identification will be required/ *Se requiere que la persona presente su identificación*

ECEAP BUS INFORMATION/Información del autobús de ECEAP

(Students that live/have childcare within 1 mile walking distance from school DO NOT qualify for transportation/ Los estudiantes que viven/tienen cuidado de niños dentro de 1 milla de distancia caminando de la escuela NO califican para transportación)

Does your child need bussing?/ ¿Necesita su hijo(a) transportación? ☐ Yes ☐ No

BUS PICK-UP ADDRESS/ ***Dirección donde el autobús recogerá al estudiante***	**BUS DROP-OFF ADDRESS/** ***Dirección donde el autobús dejará al estudiante***
Name of person responsible for your child at bus stop before school/ *Nombre de la persona responsable de su hijo(a) en la parada de autobús antes de la escuela:*	Name of person responsible for your child at bus stop after school/ *Nombre de la persona responsable de su hijo(a) en la parada del autobús después de la escuela*:
_____ Address/*Dirección*	_____ Address/*Dirección*
_____ Contact Name/*Nombre del contacto*	_____ Contact Name/*Nombre del contacto*
_____ Relationship/ *Relación*	_____ Relationship/ *Relación*
_____ Telephone/*Número telefónico*	_____ Telephone/*Número telefónico*

Parent's signature/ *Firma de los padres*: _____ Date/*Fecha*: _____

Parent's signature/ *Firma de los padres*: _____ Date/*Fecha*: _____

KENNEWICK SCHOOL DISTRICT

STUDENT HEALTH HISTORY

TO BE COMPLETED BY PARENT/GUARDIAN

To Parent: IHP Packet __ Med Form __
Info forms:
Asthma__ Allergy__ Seizure__
Initial_____ Date _____
Nurse Reviewed with parent: _____

Name of Student:_____ Date of Birth:_____Grade: _____Sex: ☐ Male ☐ Female

Information on this form is to be filled out (updated) grades K, 3, 6, 9 and transfer students.

VISION AND HEARING

☐ No ☐ Yes **Glasses/Contacts** Date of last eye exam:_____

☐ No ☐ Yes **Hearing aids** Date of last hearing exam:_____

MEDICATION

☐ No ☐ Yes Medication allergies (list):_____

☐ No ☐ Yes Medication needed at home (list):_____

☐ No ☐ Yes ***Medication needed at school (list):**_____

***Daily/or As Needed Medications at School – Medication at School form required**
State law requires written permission from a Health Care Provider and parent before any medication can be given at school (prescription/over-the-counter). A form is available from the school office and must be updated annually.

LIFE THREATENING CONDITIONS -WILL require Health Care Provider order & Individual Health Plan (IHP)

Life Threatening Medical Conditions
Washington State law mandates that students with life-threatening health conditions, where the condition would "...put the child in danger of death during the school day", have 1) medication/treatment orders written by a health care provider that is reviewed by the nurse and signed by the parent 2) an Individual Health Plan (IHP) 3) staff trained in place at school **before** your child can attend school. Forms are available from the school office and must be updated annually.

(*note a SEVERE allergy *is one that has been diagnosed by a Health Care Provider and medication has been ordered)*

☐ No ☐ Yes ***Severe Allergies, WITH EPIPEN ORDERED. Specify:**_____

☐ No ☐ Yes ***Asthma; RESCUE MED ROUTINELY, HOSPITALIZED or STEROIDS WITHIN 12 MONTHS FOR ASTHMA**__

☐ No ☐ Yes ***Diabetes, insulin dependent. Date of diagnosis:**_____. **My child uses** ☐ Pump ☐ Pen ☐ Other_____

☐ No ☐ Yes ***Seizures; EMERGENCY MED ORDERED. Seizure type:**_____**Date of last seizure:**_____

☐ No ☐ Yes ***Other condition; EMERGENCY MEDICATION/TREATMENT IS NEEDED AT SCHOOL:**_____

MEDICAL CONDITIONS *The school nurse may contact the parent/guardian for further information. Healthcare provider orders, IHP and/or nursing care plan may be needed.*

☐ No ☐ Yes **Asthma, no medication taken routinely or no med needed.**

☐ No ☐ Yes **Diabetes, non-insulin dependent. Type:**_____. **Date of diagnosis:**_____

☐ No ☐ Yes **Food aversions/sensitivities:**_____

☐ No ☐ Yes **Seizures,** no emergency medication. **Seizure type:**_____**Date of last seizure:**_____

☐ No ☐ Yes **Heart Condition:** _____

☐ No ☐ Yes **Behavioral/Emotional Concerns:** _____

☐ No ☐ Yes **Orthopedic Condition:** _____

☐ No ☐ Yes **Other Health Concerns:** _____

Does your child have any other condition that would affect his/her classroom performance or P.E. activities?
☐ No ☐Yes If yes, explain:_____

Does your child have a special health care needs such as-wheelchair, tube feeding, catheter, or other?
☐ No ☐Yes If yes, explain:_____

This information is considered confidential. It will be shared with school staff as needed, including the school health alert and health plans, during the time your child is enrolled in Kennewick School District in order to ensure the health and safety of your child unless otherwise requested by you in writing. Contact the school nurse if there are any changes to your child's health.

Parent/guardian signature _____**Date**_____

Student Nutrition History

To be completed by parent/guardian

Student Name: _____

1) Food Allergies:

☐ No ☐ Yes Does your child have any food allergies? What? _____
☐ No ☐ Yes ☐ N/A If yes, are the food allergies diagnosed by a medical professional?

☐ No ☐ Yes ☐ N/A Are any of them life threatening, requiring an epi-pen?

☐ No ☐ Yes ☐ N/A Does your child have any food sensitivities **NOT** diagnosed by a medical professional?
If yes, what? _____

2) Lactose Intolerance:

☐ No ☐ Yes Is your child lactose intolerant?
☐ No ☐ Yes ☐ N/A If yes, is the lactose intolerance diagnosed by a medical professional?
If yes, what is the prescribed milk replacement? _____

☐ No ☐ Yes ☐ N/A Does your child tolerate regular cheese and/or yogurt?

3) Special diets

☐ No ☐ Yes ☐ N/A Does your child eat a special diet due to a medical concern? _____

☐ No ☐ Yes ☐ N/A Do you avoid feeding your child certain foods for personal and/or religious reasons?
If yes, what? _____

☐ No ☐ Yes ☐ N/A Do you avoid feeding your child any beef, chicken, and turkey products?

Is there any additional information you think ECEAP staff might need to know about your child's health & nutrition?_____

_____

Parent/Guardian Signature: _____Date: _____

This information is considered confidential. It will be shared with school staff as needed during the time your child is enrolled in the Kennewick School District in order to ensure the health and safety of your child, unless otherwise requested by you in writing.

Washington State Department of CHILDREN, YOUTH & FAMILIES

KENNEWICK ECEAP

KENNEWICK SCHOOL DISTRICT ECEAP

CONSENT FOR SCREENING/HEALTH INFORMATION FORM

CONSENTIMIENTO PARA EVALUACIONES/FORMULARIO DE INFORMACIÓN DE SALUD

Each child enrolled at Kennewick ECEAP will receive a number of health and developmental screenings. If any potential concerns are identified through these screenings, you will be notified. Kennewick ECEAP staff will assist you in obtaining any additional services that might be needed.
Cada niño(a) inscrito en Kennewick ECEAP recibirá varias evaluaciones de salud y desarrollo. Usted será notificado si algunos problemas potenciales son identificados por medio de estas evaluaciones. El personal de Kennewick ECEAP le asistirá en obtener servicios adicionales los cuales puedan ser necesarios.

The screenings for each child are as follows/*Las evaluaciones para cada niño son las siguientes***:**

Yes/*Sí*	**No**		
❒	❒	**Developmental Screening** *Evaluación de Desarrollo*	- **Done through a series of fun activities (assessing the areas of language, motor, cognitive, social/emotional, and self-help)** - *Realizado por medio de actividades divertidas (evaluando áreas de lenguaje, destrezas motoras, cognitivas, socioemocionales, y auto ayuda)*
❒	❒	**Behavioral Screening** *Evaluación de Comportamiento*	- **Done through parent and teacher observation as needed** - *Realizado a través de la observación de padres y profesores, según sea necesario*
❒	❒	**Hearing Screening** *Evaluación del oído*	- **Done with the use of an Otoacoustic Hearing Machine (OAE)** - *Realizado por medio de equipo autoacústico*
❒	❒	**Vision Screening** *Evaluación de la Vista*	- **Done using a SPOT vision screening machine** - *Realizado usando una maquina Polaroid que evalua la vista*
❒	❒	**Height and Weight Screening** *Evaluación del Peso y Estatura*	- **Checking for under or over weight status** - *Para determinar bajo o sobre peso*

As the parent/guardian of/*Como padre/tutor de* _____,
(Child's name/*Nombre del niño(a)***)**

I give permission to Kennewick ECEAP or designated agencies to do all the screenings/testing above <u>except those I have indicated "No."</u>
Yo doy permiso al personal de Kennewick ECEAP o a agencias designadas para hacer todas las evaluaciones dichas anteriormente con la <u>excepción de los que indican que "No</u>."

_____ _____
Parent/Guardian Signature/ *Firma de Padre/Tutor* **Date/***Fecha*

Washington State Department of CHILDREN, YOUTH & FAMILIES

KENNEWICK SCHOOL DISTRICT ECEAP

Authorization to Release Confidential Health Information
Autorización de Información Confidencial de Salud

PARENT AND CHILD INFORMATION *Información de el/la niño/a y de los padres*

Child's First Name—***Primer Nombre del Nino/a***	Last Name ***Apellido***	Middle **Segundo Nombre**

Child's date of birth /***Fecha de nacimiento de el/la niño/a:***	Parent/Guardian Names / ***Nombres de los Padres/Tutores***

INFORMATION RELEASED TO:

Kennewick ECEAP	123 S. Kent St, Kennewick, WA 99336 Phone: (509) 222-5027 **FAX: (509) 222-5037**

Reason for Release of Information
At the request of the parent/legal guardian for the health, safety and Education Purposes of their child while enrolled Kennewick ECEAP

MEDICAL PROVIDER Proveedor medíco

Provider or Clinic Name/**Nombre de Proveedor o la clinica:**	Telephone/**Telefono:**	Fax:

Record: I authorize the following records/information to be disclosed
Yo autorizo los siguientes registros/ Información

- ☐ Medical Exam & Treatment/ **Examen medíco y tratamiento**
- ☐ Immunization Records / **Registros de inmunización**
- ☐ Child Health Plan/ **Plan de salud del niño(a)**

DENTAL PROVIDER Proveedor dental

Provider or Clinic Name/**Nombre de Proveedor o la clinica:**	Telephone/**Telefono:**	Fax:

Record: I authorize the following records/information to be disclosed
Yo autorizo los siguientes Registros/ Información

- ☐ Dental Exam & Treatment/ Examen dental y tratamiento

PARENT AUTHORIZATION ***Autorización del Padre***

This permission is valid from the signed date until August 31, 2024
I understand that: ***Yo entiendo que:***

- I may revoke or withdraw my permission in writing at any time, but that will not affect information already disclosed ***Puedo revocar o retirar mi permiso por escrito en cualquier momento, pero no afectará la información ya divulgada***
- I understand that these records will be treated as confidential by Kennewick ECEAP under the provision of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. ***Entiendo que estos registros serán tratados como confidenciales por Kennewick ECEAP bajo la disposición de los derechos de Educación de la familia la ley y privacidad. FERPA prohíbe la divulgación de información personal indefinible sin consentimiento excepto en circunstancias limitadas***
- Information disclosed through this authorization may be shared and is no longer protected by HIPAA (Health Insurance Portability and Accountability Act) ***información revelada por medio de esta autorización puede ser compartida y ya no está protegido por HIPAA***
- A copy of this form is valid to give permission to disclose records. ***una copia de este formulario es válida para dar permiso para divulgar los registros***
- Authorizing the disclosure of this information is voluntary. ***Autorizar la divulgación de esta información es voluntaria.***

Authorization by (signature) ***Autorización (firma del Padre)***	Relationship to Child ***Relación con el niño***
Date Signed ***Fecha***	Telephone # ***Teléfono***
Print Name ***Nombre impreso***	

Dave Bond, Superintendent
Dr. Chuck Lybeck, Associate Superintendent, Curriculum
Greg Fancher, Assistant Superintendent, Elementary Education
Ron Williamson, Assistant Superintendent, Secondary Education
Doug Christensen, Assistant Superintendent, Human Resources
Ron Cone, Executive Director, Information Technology
Vic Roberts, Executive Director, Business Operations
Robyn Chastain, Director, Communications and Public Relations

KENNEWICK SCHOOL DISTRICT

Home Language Survey

The Home Language Survey is given to *all* students enrolling in Washington schools.

Student Name: (Last, First, Middle)	**Grade:**	**Date:**
Parent/Guardian Name:	**Date of Birth:**	
Parent/Guardian Signature _____	**Phone Number:**	

Right to Translation and Interpretation Services Indicate your language preference so we can provide an interpreter or translated documents, free of charge, when you need them.	All parents have the right to information about their child's education in a language they understand. 1. In what language(s) would your family prefer to communicate with the school? _____
Eligibility for Language Development Support Information about the student's language helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.	2. What language did your child learn first? _____ 3. What language does your child use the most at home? _____ 4. What is the primary language used in the home, regardless of the language spoken by your child? _____ 5. Has your child received English language development support in a previous school? Yes___ No___ Don't Know___
Prior Education Your responses about your child's birth country and previous education: • Give us information about the knowledge and skills your child is bringing to school. • May enable the school district to receive additional federal funding to provide support to your child. *This form is not used to identify students' immigration status.*	6. In what country was your child born? _____ 7. Has your child ever received formal education outside of the United States? (Kindergarten – 12th grade) _____Yes _____No If yes: Number of months: _____ Language of instruction: _____ 8. When did your child first attend a school in the United States? (Kindergarten – 12th grade) _____ Month Day Year
	9. Did you move to this area for the purpose of finding work in agriculture or agricultural related work (such as farm equipment operation, food processing)? _____ Yes _____ No

Thank you for providing the information needed on the Home Language Survey. Contact your school district if you have further questions about this form or about services available at your child's school.