Washington State Department of CHILDREN, YOUTH & FAMILIES

KENNEWICK SCHOOL DISTRICT ECEAP

## ENROLLMENT 2024-2025

## 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:**
Erika Sanchez, ECEAP Secretary Email:
erika.sanchez@ksd.org
123 S Kent St. **Portable 4**
Kennewick, WA 99336
Phone: 509-222-5027
Fax: 509-222-5037

# 2024-2025 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**

| **Preferred Classroom Session** | |
|---|---|
| ☐ AM Session 8:20 AM to 11:20 AM | ☐ Full School Day 8:20 AM to 3:35 PM |
| ☐ PM Session 12:35 PM to 3:35 PM | ☐ Dual Full School Day 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, as defined by WAC 110-425-0030? | ☐ 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 |
| **SNAP** - Is this child from a family who is eligible for the US Department of Agriculture Supplemental Nutrition Assistance Program or SNAP, called Basic Food in Washington? | ☐ Yes | ☐ No |

| **Housing** (select one) | |
|---|---|
| ☐ | Rent or own an adequate residence |
| ☐ | Doubled-up in a cooperative living arrangement with relatives or friends |
| ☐ | Doubled-up with another family due to loss of housing, economic hardship, or 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 | Child's first language: |
| ☐ | Mostly English, and some of another home language | |
| ☐ | Some English, but mostly another home language | Child's second language: |
| ☐ | English and another language at age level (bilingual) | |
| ☐ | Only a home language other than English | |

| Is this child Hispanic or Latino? ☐ Yes ☐ No | | |
|---|---|---|
| □ Argentinian | □ Ecuatorian (Ecuadorian) | □ Puerto Rican |
| □ Bolivian | □ Guatemalan | □ Salvadoran |
| □ Chilean | □ Honduran | □ Spanish |
| □ Columbian | □ Mexican or Mexican-American (Chicano) | □ Uruguayan |
| □ Costa Rican | □ Nicaraguan | □ Venezuelan |
| □ Cuban | □ Panamanian | □ Latin American |
| □ Dominican | □ Peruvian | □ Other Hispanic or Latino ______________ |

| **What race(s) do you consider this child?** *(Check all that apply)* | | |
|---|---|---|
| □ **White** | □ **American Indian** | □ **Native Hawaiian or Other Pacific Islander** |
| □ **Black or African American** | □ Chehalis | □ Fijian |
| □ **Alaska Native** | □ Chinook | □ Guamanian |
| □ Aleut (Unangan) | □ Colville | □ Kosraean |
| □ Athabaskan | □ Cowlitz | □ Mariana Islander |
| □ Eskimo (Inupiaq or Yupik) | □ Duwamish | □ Marshall Islander |
| □ Eyak | □ Hoh | □ Melanesian |
| □ Haida | □ Jamestown | □ Micronesian |
| □ Tlingit | □ Kalispel | □ Native Hawaiian |
| □ Tsimshian | □ Kikiallus | □ Palauan |
| □ Other Alaskan Native | □ Lower Elwha | □ Papua New Guinean |
| | □ Lummi | □ Ponapean (Pohnpeian) |
| □ **Asian** | □ Makah | □ Samoan |
| □ Asian Indian | □ Muckleshoot | □ Solomon Islander |
| □ Bangladeshi | □ Nisqually | □ Tahitian |
| □ Bhutanese | □ Nooksack | □ Tarawa Islander |
| □ Burmese | □ Port Gamble Klallam | □ Tokelauan |
| □ Cambodian/Kampuchean | □ Puyallup | □ Tongan |
| □ Chinese | □ Quiluete | □ Trukese (Chuukese) |
| □ Filipino | □ Quinalt | □ Vanuatuan/New Hebrides |
| □ Hmong | □ Samish | □ Yapese |
| □ Indonesian | □ Sauk-Suiattle | □ Other Pacific Islander |
| □ Japanese | □ Shoalwater | |
| □ Korean | □ Skokomish | |
| □ Laotian | □ Snohomish | |
| □ Madagascar | □ Snoqualmie | |
| □ Malayan | □ Snoqualmoo | |
| □ Maldivian | □ Spokane | |
| □ Mongolian | □ Squaxin Island | |
| □ Nepali | □ Steilacoom | |
| □ Pakistani | □ Stillaquamish | |
| □ Singaporean | □ Swinomish | |
| □ Sri Lankan | □ Tulalip | |
| □ Taiwanese | □ Upper Skagit | |
| □ Thai | □ Yakama | |
| □ Vietnamese | □ Other American Indian | |
| □ Other Asian | | |
| | | |

## 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 |
| | | | | | |
| | | | | | |
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| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**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<br>If yes, what language(s) do you speak? | | | |
| Physical Address | Apt Number | City | State | Zip |
| Mailing Address (if different from 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 <u>same</u> household (Names):

____________________ ____________________

□ Two parents/guardians in <u>two</u> 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 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<br>If yes, what language(s) do you speak? | | | |
| Physical Address | Apt Number | City | State | Zip |
| Mailing Address (if different from 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<br>**Name:** | Parent/Guardian #2<br>**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): | | |
| ☐ 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 6 hours, four or five days a week

☐ Working Day – available all day, all year, like a child care 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 child care 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 10***

- Monthly grant or payment for fostercare, 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 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***<br>*If no, and your current circumstances have recently changed, please explain:*<br>________________________________________________________ | | | |
|---|---|---|---|
| ☐ Loss of wage earner | ☐ Divorce or separation | ☐ Unplanned loss | ☐ Reduced work hours |
| ☐ Health/Injury | ☐ Loss of benefits | ☐ Job loss- lack of access or ability to afford childcare for newborn | |
| ☐ Similar unexpected circumstance (explain) | | | |
| What is your monthly income? | | For which month? | |

| Section 10: Previous Enrollment | |
|---|---|
| ☐ Head Start | ☐ ECLIPSE- Early Childhood Intervention and Prevention Services |
| ☐ Migrant/Seasonal Head Start anywhere in WA | |
| ☐ Early Head Start (Name of Grantee): | ☐ ESIT – Early Support of Infants (Name of Provider): |
| ☐ Any birth to three home visiting program and toddler | ☐ Part C IDEA Early Intervention program in another state (Name of state and provider): |
| ☐ Early ECEAP (Name of Contractor): | ☐ No previous early learning preschool enrollment |

| 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 waiting for IEP to be issued or parent/guardian declined services | | |
| ☐ This child has a diagnosed developmental delay or disability with no IEP | | |
| ☐ This child has 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 | ☐ Intellectual disability | ☐ Specific learning disability |
| ☐ Deaf-blindness | ☐ Multiple disabilities | ☐ Speech or Language Impairment |
| ☐ Developmental delay | ☐ Orthopedic impairment | ☐ Traumatic brain injury |
| ☐ Emotional disturbance | ☐ Visual impairment | ☐ Other health Impairment |
| ☐ Hearing 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*)<br>• 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)<br>• 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 |
| Has this child experienced 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 tribla 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<br>Name: | Parent/Guardian 2<br>Name: |
| 6th grade or less | ☐ | ☐ |
| 7th to 12th grade, no diploma or GED | ☐ | ☐ |
| High school diploma or GED | ☐ | ☐ |
| Some college | ☐ | ☐ |
| Professional certificate (includes vocational schools) | ☐ | ☐ |
| Associates 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:<br>• Severely impact child development or attendance? | ☐ Yes | ☐ No | ☐ Unknown |
| • Moderately impacts child development or attendance? | ☐ Yes | ☐ No | ☐ Unknown |
| ❖ If yes, please describe: | | | |
| Was this child born preterm (less than 37 weeks),<br>or weighed less than 5.5 pounds at birth? | ☐ Yes | ☐ No | ☐ Unknown |
| Does this child have medical insurance or coverage?<br>□ Washington Apple Health for Kids/ Provider One Services Card<br>□ Military Coverage □Private Medical Insurance □ Tribal Coverage | ☐ Yes | ☐ No | ☐ Unknown |
| Does this child have a regular doctor or medical clinic?<br>Name of clinic or provider: ___________________________________<br>Name of medical professional: _______________________________<br>Phone: ____________________________ | ☐ Yes | ☐ No | ☐ Unknown |
| Did this child have a well-child exam within the last 12 months?<br>❖ Date of last well-child exam before applying for ECEAP:<br>___________________ ☐ Date Unknown | ☐ Yes | ☐ No | ☐ Unknown |
| Does this child have dental insurance or coverage?<br>□ Washington Apple Health for Kids/ Provider One Services Card<br>□ Military Coverage □Private Medical Insurance □ Tribal Coverage<br>□ ABCD (not available in all counties) | ☐ Yes | ☐ No | ☐ Unknown |
| Does this child have a regular doctor or dental clinic?<br>Name of clinic or provider: _______________________________<br>Name of dental professional: _____________________________<br>Phone: ____________________________ | ☐ Yes | ☐ No | ☐ Unknown |
| Did this child have a dental screening within the last 6 months?<br>❖ Date of last dental screening before applying for ECEAP:<br>___________________ ☐ Date Unknown | ☐ Yes | ☐ No | ☐ 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 (14 and over) who are authorized to pick my child up from school and bus stop.**
***Adultos (14 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***

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:*

______________________________
Address/*Dirección*

______________________________
Contact Name/*Nombre del contacto*

______________________________
Relationship/ *Relación*

______________________________
Telephone/*Número telefónico*

**BUS DROP-OFF ADDRESS/**
***Dirección donde el autobús dejará al estudiante***

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*

______________________________
Contact Name/*Nombre del contacto*

______________________________
Relationship/ *Relación*

______________________________
Telephone/*Número telefónico*

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

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

# 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**______________

KSD:Health History form: 3/2016

Washington State Department of CHILDREN, YOUTH & FAMILIES

KENNEWICK SCHOOL DISTRICT ECEAP

# Student Nutrition History

To be completed by parent/guardian

Student Name: ______________________________ DOB: ________________

**1. Does your child have any of the following:**

☐ Yes ☐ No Food allergies diagnosed by a medical professional *(describe):* ____________________

☐ Yes ☐ No If yes, are any of them life threatening, requiring an epi-pen?

☐ Yes ☐ No Food sensitivities **not** diagnosed by a medical professional?

**2. Does your child have lactose intolerance?**

☐ Yes ☐ No Has lactose intolerance been diagnosed by a medical professional?

☐ Yes ☐ No Can your child have regular cheese and/or yogurt?

What does your child drink in place of cow's milk? *(ECEAP provides lactose free milk unless there is a medical prescription requiring a special type of milk):* ______________________________

***3.*** **Special diets** ***(ECEAP does not serve pork products)***

☐ Yes ☐ No Does your child eat a special diet due to medical concerns?

☐ Yes ☐ No Do you avoid feeding your child certain foods for personal reasons?

☐ Yes ☐ No Do you avoid feeding your child certain foods for religious reasons?

☐ Yes ☐ No Can your child eat beef, chicken, and turkey?

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

______________________________________________________________

# Dental History

To be completed by parent/guardian

☐ Yes ☐ No Has your child had any cavities?

☐ Yes ☐ No Has your child had any dental treatments?

☐ Yes ☐ No Does your child complain of mouth/tooth pain?

☐ Yes ☐ No Has your child ever had a bad dental experience?

☐ Yes ☐ No Does your child have any uncompleted dental treatments?

How often do you help your child brush his/her teeth? ______________________________

If you answered Yes to any of these questions, please describe:

______________________________________________________________

______________________________________________________________

**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**<br>*Evaluación de Desarrollo* | - **Done through a series of fun activities (assessing the areas of language, motor, cognitive, social/emotional, and self-help)**<br>- *Realizado por medio de actividades divertidas (evaluando áreas de lenguaje, destrezas motoras, cognitivas, socioemocionales, y auto ayuda)* |
| ☐ | ☐ | **Behavioral Screening**<br>*Evaluación de Comportamiento* | - **Done through parent and teacher observation as needed**<br>- *Realizado a través de la observación de padres y profesores, según sea necesario* |
| ☐ | ☐ | **Hearing Screening**<br>*Evaluación del oído* | - **Done with the use of an Otoacoustic Hearing Machine (OAE)**<br>- *Realizado por medio de equipo autoacústico* |
| ☐ | ☐ | **Vision Screening**<br>*Evaluación de la Vista* | - **Done using a SPOT vision screening machine**<br>- *Realizado usando una maquina Polaroid que evalua la vista* |

**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 except those I have indicated "No."**
*Yo doy permiso al personal de Kennewick ECEAP o a agencias designadas para hacer todas las evaluaciones dichas anteriormente con la excepción de los que indican que "No."*

________________________________________ ____________________
**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<br>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, 2025**

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

# 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**<br>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.<br><br>1. In what language(s) would your family prefer to communicate with the school?<br>____________________________________ |
| **Eligibility for Language Development Support**<br>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?<br>____________________________________<br><br>3. What language does your child use the most at home?<br>____________________________________<br><br>4. What is the primary language used in the home, regardless of the language spoken by your child?<br>____________________________________<br><br>5. Has your child received English language development support in a previous school? Yes___ No___ Don't Know___ |
| **Prior Education**<br>Your responses about your child's birth country and previous education:<br>• Give us information about the knowledge and skills your child is bringing to school.<br>• May enable the school district to receive additional federal funding to provide support to your child.<br><br>*This form is not used to identify students' immigration status.* | 6. In what country was your child born? ____________________<br><br>7. Has your child ever received formal education outside of the United States? (Kindergarten – 12th grade) _____Yes _____No<br><br>If yes: Number of months: _______________<br>Language of instruction: _______________<br><br>8. When did your child first attend a school in the United States? (Kindergarten – 12th grade)<br>________________________<br>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)?<br>_______ 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.