Washington State Department of CHILDREN, YOUTH & FAMILIES

KENNEWICK SCHOOL DISTRICT

ENROLLMENT 2020-2021

ECEAP ELIGIBILITY CRITERIA

Please use BLUE ink 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.

- Educational Experience – Preschool Classes
- Family Support Services Including Home Visits
- Provides Comprehensive Health & Nutrition Services
- Opportunities for Parent Involvement
- Including a minimum of 3 Parent Teacher Conferences & 3 Home Visits

THE FOLLOWING INFORMATIN IS NEEDED FOR ENROLLMENT & ELIGIBILITY:

1. Income verification from previous year stating amounts **(if applicable)**:
   - W-2s
   - Tax Return (1040) or IRS Transcript
   - 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. Address verification of residential status. **Please bring PUD bill or rental/lease agreement**.

5. Provider One Card/Private Insurance Card

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

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

To enroll or for more information contact:
ECEAP
Kennewick School District
1000 W. 4th Avenue
Kennewick, WA 99336
509-222-5027

Washington State Department of CHILDREN, YOUTH & FAMILIES

2020-2021 ECEAP Prescreen & Application

Return to: Kennewick ECEAP 1000 W. 4th Ave. (509) 222-5027

KENNEWICK SCHOOL DISTRICT

Preferred Classroom Session: ☐ AM ☐ PM ☐ No Preference

Child Information

School year applying for: 2020-2021

Legal First Name______________________Middle Name___________________Legal Last Name ______________________

Child's birth date_____/_____/_______ Nickname_____________________Gender Identity ______________________

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

CPS - Is this child's family currently receiving Child Protective Services (CPS), Family Assessment Response (FAR), or Indian Child Welfare (ICW), 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 grant? ☐ Yes ☐ No

Adopted after foster/kinship care - Was this child adopted after foster or 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 save money 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 only 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

If yes, check all that apply:

- ☐ 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 (describe)____________________

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 (describe)____________

☐ **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 (describe)________________

☐ **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 (describe)________________

☐ **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 (describe)____________

1. 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 federal poverty level.

First Name	Last Name	Birthdate	Relationship to ECEAP Child	Does the parent or guardian of the ECEAP child 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:
Family size for FPL chart ______
For children in foster care, kinship, or adopted after foster or kinship care, count family size as 1.
For all others, count people with Yes for both questions above.

Family Contact Information

Do you need an interpreter to communicate with English speakers? ☐ Yes ☐ No

If yes, what language(s) do you speak? ____________________________

Physical Street Address________________________________Apt #____City________________Zip________

Mailing Address (if different)____________________________City_____________________Zip__________

Email (Important for use of ECEAP Class Dojo)____

Phone____Alternate Phone _______________________

2. Child lives with:

☐ One parent/guardian (Name)____ ***Skip to section 3.***

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

_____________________________ ***Skip to section 3.***

☐ Two parents/guardians in two households

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 3.***

If **no**, does one parent receive child support payments from the other household? ☐ Yes ☐ No

If **yes**, which parent receives the child support payments? _______________

Spouse of this parent, if any:______________________________ ***Skip to section 3.***

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 1___________________________Household 2______________________

Contact Info for Household 2:

Physical Street Address____________________Apt #____City___________Zip________

Mailing Address (if different)________________City__________________Zip________

Email _________________________________

Phone_________________________________Alternate Phone ___________________

3. Parent Employment, Training, and Other Activities

Answer the following questions for each parent/guardian listed in question #2.

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 Work First.
- Do not count the same CPS child care 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 child care and work/school?	☐ Yes ☐ No	☐ Yes ☐ No
a. If yes, hours per week (maximum 10)		
CPS/FAR/ICW child care hours not counted above?	☐ Yes ☐ No	☐ Yes ☐ No
a. Additional hours per week of child care approved by CPS		
Approved Work First 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:		

4. 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 - Describe other:____

5. 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 child care center.

6. 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

7. Income Received by Child's Parent(s) or Guardian(s)

For children in foster or kinship care or adopted after foster or kinship care, fill in this box if applicable and *skip to Section 8*

Monthly grant or payment for foster care, kinship care, or adoption support $__________

# of children covered by this grant or payment ____________

Case # or Client ID#, if any:______________________ Payment source: ☐DSHS ☐SSI ☐Tribe ☐Other

Did you 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:

Enter all family income for one year in the chart below.

Select either: ☐ Previous calendar year ☐ Previous 12 months

Person(s) with Income	Type	Weekly Amount	# of Weeks Received	Monthly Amount	# of Months Received	Annual Amount
	W-2					$
	W-2					$
	Tax return (1040) or IRS transcript					$
	Tax return (1040) or IRS transcript					$
	Pay stubs for 12 months					$
	Pay stubs for 12 months					$
	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			$		$
	TANF cash assistance			$		$
	Child-only TANF or foster care grant for non-ECEAP child			$		$
	Unemployment	$				$
	Workers Compensation (L&I)	$				
	Tribal income (taxable)					$
	Other income not classified above			$		$
						$
Subtract	Child support paid to another household, if required by a legally-binding child support order			$		-$
					TOTAL	$

Do you still receive the income above? ☐ Yes ☐ No ***If yes, skip to section 8.***

If no, and your circumstances have recently changed, please explain:

☐ Loss of wage earner ☐ Divorce or separation ☐ Unplanned job loss ☐ Reduced work hours
☐ Health/Injury ☐ Loss of benefits ☐ Similar unexpected circumstance (explain) ______________

What is your monthly income? $_______________for which month? _____________________________

8. Previous Enrollment

This child was previously enrolled in:

- ☐ Head Start at your agency
- ☐ Head Start with a different agency
- ☐ Migrant/Seasonal Head Start anywhere in Washington
- ☐ Any birth-to-three home visiting program
- ☐ Early Head Start
  Name of EHS Grantee___________________________
- ☐ ESIT - Early Support for Infants and Toddler
  Name of ESIT Provider____________________________
- ☐ Part C IDEA Early Intervention Program in another state
  Name of State and Provider________________________

9. IEP or Suspected Delay

- ☐ This child has an Individualized Education Program (IEP).
- ☐ 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 10.**

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

Name of ESIT Provider___________________________________State of ESIT Provider _________________________

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

10. Has this child been asked to leave a child care or preschool because of behavior issues? ☐ Yes ☐ No

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

11. 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:

- 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 is a migrant worker or seasonal agricultural worker? (51% or more of family income from agricultural 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 parent who is incarcerated in jail, prison or a detention center? ☐ Yes ☐ No

Has this child experienced the loss of a parent, 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 been homeless 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 received services from CPS/FAR/ICW services or been involved with law enforcement/court system regarding child abuse, neglect, or sexual assault in the past? ☐ 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? ____

12. 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 (includes vocational schools)		
Associate degree		
Bachelor's degree		
Master's degree or doctorate		

13. Health Information ***Please attach a copy of the child's immunization record***

Does this child have a chronic physical or mental health condition that:

Severely impacts child development or attendance? ☐ Yes ☐ No

Moderately impacts child development or attendance? ☐ Yes ☐ No

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 (optional) ______________________________

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 Dental Coverage ☐ Private Dental Insurance
☐ ABCD (not available in all counties) ☐ Tribal Coverage

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

Name of clinic or provider ______________________________

Phone (optional) ______________________________

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* ___________________

OFFICE USE ONLY

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 ____

*Signature*____ *Date* ___________________

Washington State Department of CHILDREN, YOUTH & FAMILIES

EMERGENCY & PERMISSION FOR SERVICES

KENNEWICK ECEAP

KENNEWICK SCHOOL DISTRICT

CHILD'S NAME_______________________________________DATE OF BIRTH___________________
ADDRESS_______________________________________CHILD CARE ☐ YES ☐ NO
CHILD CARE PROVIDER_______________________________ PHONE NUMBER__________________
RESTRAINING ORDER 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

<u>I GIVE PERMISSION FOR MY CHILD TO</u>

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

<u>I GIVE ECEAP STAFF PERMISSION TO</u>

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

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

Child's Name/ *Nombre del niño*: ______________________________

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

Phone No/ *Número telefónico*: ______________________________

Adults (16 and over) who are authorized to pick my child up from school and bus stop.
Los adultos (16 años de edad o mayor) que están autorizados de recoger a 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*

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

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

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

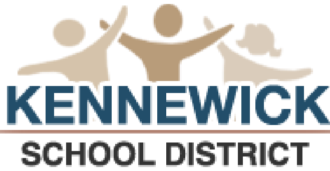
The Home Language Survey is given to *all* students enrolling in Washington schools.

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

Right to Translation and Interpretation Services 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.

Dave Bond, Superintendente
Dr. Chuck Lybeck, Superintendente Asociado, Plan de Estudios
Greg Fancher, Asistente al Superintendente, Educación Primaria
Ron Williamson, Asistente al Superintendente, Educación Secundaria
Doug Christensen, Asistente al Superintendente, Recursos Humanos
Ron Cone, Director Executivo, Tecnología Informática
Vic Roberts, Director Executivo, Operaciones Comerciales
Robyn Chastain, Directora, Comunicación y Relaciones Públicas



Encuesta de Idiomas en el Hogar

La Encuesta de idiomas en el Hogar se entrega a *todos* los alumnos que se inscriben en una escuela de Washington.

Nombre del alumno: (Apellido, Nombre)	**Grado:**	**Fecha:**
Nombre del padre, madre o tutor:	**Fecha de Nacimiento:**	
Firma del padre, madre o tutor ______________________________	**Numero de Teléfono:**	

Derecho a los servicios de traducción o interpretación Indique el idioma de su preferencia para que podamos brindarle un intérprete o documentos traducidos, sin cargo alguno, cuando los necesite.	Todos los padres tienen el derecho de recibir información sobre la educación de su hijo en un idioma que entiendan. 1. ¿En qué idioma prefiere su familia comunicarse con la escuela? ____
Requisitos para recibir apoyo en capacitación de idiomas La información sobre el idioma del alumno nos ayuda a identificar a los alumnos que reúnen los requisitos para recibir apoyo para formar las habilidades de idioma necesarias para tener éxito en la escuela. Es posible que sea necesario hacer una evaluación para determinar si se requiere ayuda con el idioma.	2. ¿Qué idioma aprendió su hijo primero? _________________________________ 3. ¿Qué idioma utiliza más su hijo en casa? _________________________________ 4. ¿Cuál es el idioma principal que se utiliza en casa, independientemente del idioma que habla su hijo? _________________________________ 5. ¿Ha recibido su hijo apoyo en capacitación del idioma inglés en una escuela anterior? Sí____No____No sé____
Educación previa Sus respuestas sobre el país de nacimiento de su hijo y su educación previa: • Bríndenos información sobre el conocimiento y las aptitudes que su hijo trae a la escuela. • Esto puede ayudar a que el distrito escolar reciba fondos federales adicionales para brindarle apoyo a su hijo. *Este formulario no se utiliza para identificar la situación migratoria de los alumnos.*	6. ¿En qué país nació su hijo? ___________________ 7. ¿Alguna vez ha recibido su hijo educación formal fuera de Estados Unidos? (Kindergarten – 12.º grado) _____Sí______No Si la respuesta es Sí: Número de meses: ______________ Idioma de formación: ______________ 8. ¿Cuándo asistió su hijo por primera vez a la escuela en Estados Unidos? (Kindergarten – 12.º grado) ______________________ Mes Día Año
	9. ¿Se mudó con el propósito de encontrar trabajo en la agricultura o trabajo relacionado con la agricultura (tal como operación de maquinaria en las granjas, procesamiento de alimentos)? _______Sí _______No

Gracias por brindarnos la información necesaria en la Encuesta de Idiomas en el Hogar. Póngase en contacto con su distrito escolar si tiene más preguntas sobre este formulario o sobre los servicios que ofrece la escuela de su hijo.

Washington State Department of
CHILDREN, YOUTH & FAMILIES

KENNEWICK
SCHOOL DISTRICT

🚌 ECEAP BUS INFORMATION 🚌
INFORMACIÓN DEL AUTOBÚS DE ECEAP

Child's Name/ *Nombre del estudiante*: ____________________

Parent's Name/ *Nombre de los padres*: ____________________

Home Address/ *Dirección*: ____________________

Telephone/ *Número telefónico*: ____________________

BUS PICK-UP ADDRESS/
Dirección donde el autobús recogerá al estudiante

________Home Address/ *Dirección de su casa*

________Other Address **(complete information below)** / *Otra dirección* ***(llene la forma que sigue)***

Name of person responsible for your child at bus stop before school/ *Nombre de la persona responsable por su niño a la parada del autobús antes de la escuela:*

____
Contact Name/*Nombre del contacto*

____
Relationship/ *Relación*

____
Address/*Dirección*

____
Telephone/*Número telefónico*

Emergency Contact/ *Contacto en caso de una emergencia:*

____

____
Telephone/ *Número de telefónico* #

BUS DROP-OFF ADDRESS/
Dirección donde el autobús dejara a su estudiante

________Home Address/ *Dirección de su casa*

________Other Address **(complete information below)** / *Otra dirección* ***(llene la forma que sigue)***

Name of person responsible for your child at bus stop after school/ *Nombre de la persona responsable por su niño a la parada del autobús antes de la escuela*:

____
Contact Name/*Nombre del contacto*

____
Relationship/ *Relación*

____
Address/*Dirección*

____
Telephone/*Número telefónico*

Emergency Contact/ *Contacto en caso de una emergencia:*

____

____
Telephone/ *Número telefónico* #

Kennewick School District

1000 W. 4th Ave

Kennewick, WA 99336

Student Housing Questionnaire

Please use one form per student. Return to school registration office within 14 days of receipt. If you require additional copies, please contact your school.

Name of Student: ______________________ ______________________ ______________________
First Middle Last

Name of School:______________________Grade:__________Birthdate:__________________Age: __________
Month/Day/Year

Sex: ☐ Male ☐ Female

The answers to the following questions can help determine the services this student may be eligible to receive under the McKinney-Vento Act 42 U.S.C. 11435.

1. Is this student's home address a temporary living arrangement? ☐ Yes ☐ No
2. Is this a temporary living arrangement due to a loss of housing or economic hardship? ☐ Yes ☐ No
3. Is this student awaiting foster care placement? ☐ Yes ☐ No
4. As a student, are you living with someone other than your parent or legal guardian? ☐ Yes ☐ No

If you answered YES to **any** of the above questions, please complete the remainder of this form.
If you answered NO to all of the above questions, you may stop here.

Where is this student currently living? (check box)

☐ Temporarily with another family because we cannot afford or find affordable housing.

☐ With an adult that is not a parent or legal guardian, or alone without an adult.

☐ In a hotel/motel.

☐ In a vehicle of any kind, RV park or campground, abandoned building or substandard housing.

☐ In an emergency/transitional shelter.

☐ Other

ADDRESS OF CURRENT RESIDENCE: ____

(OR)

NAME OF MOTEL/SHELTER OF CURRENT RESIDENCE: ______________________________________

(OR)

NAME OF "GENERAL AREA" OF CURRENT RESIDENCE: ______________________________________

PHONE NUMBER OR CONTACT NUMBER:_______________NAME OF CONTACT: ____________________

Print name of parent(s)/legal guardian(s): ____
(Or unaccompanied youth)

Signature of parent/legal guardian:______________________________________Date:________________
(Or unaccompanied youth)

For School Staff Only: Forward questionnaire to Federal Programs, Attn: Homeless Support Coordinator

Washington State Department of CHILDREN, YOUTH & FAMILIES

KENNEWICK SCHOOL DISTRICT
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Student Health History

To be completed by parent/guardian

Students Name:______________________________Date of Birth: ___________

Sex: ☐Male ☐Female

☐ No ☐ Yes Glasses/Contacts, Date of last eye evaluation: ____

☐ No ☐ Yes Hearing Aids, Date of last hearing exam: ____

Daily Medications

State law requires written permission from a Health Care Provider and parent before any medication (prescription or over-the-counter) can be given at school. A form is available from the school office.

☐ No ☐ Yes Medication needed at school (list): ____

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

Life Threatening or Chronic Health 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 medication/treatment orders and an Individual Health Plan in place at school **before** your child can attend school.

Life Threatening Conditions (WILL require Health Care Provider orders)

Please check all that apply:

* Severe allergy means diagnosed by a Health Care Provider and medication, such as an EpiPen has been prescribed.

☐ No ☐ Yes Severe allergic reaction to nuts (list):_________________________ EpiPen ☐ Yes ☐ No

☐ No ☐ Yes Severe allergic reaction to bee stings? EpiPen ☐ Yes ☐ No

☐ No ☐ Yes other severe allergies – affecting school? Specify:_________________ EpiPen ☐ Yes ☐ No

☐ No ☐ Yes Severe Asthma? Regularly takes medication for asthmatic condition or hospitalized within last 5 years for Asthmatic condition.

☐ No ☐ Yes Diabetes?

☐ No ☐ Yes Other? ____

Chronic Health Conditions (MAY require Health Care Provider orders)

Please check all that apply and explain:

☐ No ☐ Yes Asthma? Takes medication only when needed.

☐ No ☐ Yes Seizure Disorder?

Types of seizures and date of last seizure: ____

☐ No ☐ Yes Heart Condition? ____

☐ No ☐ Yes Behavioral/Emotional concerns? ____

☐ No ☐ Yes Orthopedic conditions? ____

☐ No ☐ Yes other health concerns? ____

Does your child have any other condition that would affect his/her classroom performance or outdoor activities?

☐ No ☐ Yes If yes, explain:

____

____

____

Washington State Department of CHILDREN, YOUTH & FAMILIES

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

KENNEWICK SCHOOL DISTRICT — Education is the bridge to the future.

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/Guardián***

INFORMATION RELEASED TO:

Kennewick ECEAP	1000 W. 4th Avenue 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, 2021

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 el 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***	

Washington State Department of CHILDREN, YOUTH & FAMILIES

KENNEWICK SCHOOL DISTRICT
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Health:

☐ No ☐ Yes Were you told that your child was born early or premature? How early? ____________

☐ No ☐ Yes Were there significant complications during pregnancy?

☐ No ☐ Yes Were drugs, alcohol or cigarettes part of family life during pregnancy?
List any Drugs/Alcohol/Medications used during pregnancy?

____

☐ No ☐ Yes Has your child had any serious illnesses, injuries, surgeries or seen a specialist?
If YES what/when: ____

☐ No ☐ Yes Does your child take a prescribed fluoride supplement?

Nutrition:

☐ No ☐ Yes Does your child have any food allergies? ____________________________________

☐ No ☐ Yes Does your child have a lactose intolerance?

☐ No ☐ Yes Does your child have a special diet? If Yes what? ______________________________

☐ No ☐ Yes Do you avoid feeding your child certain foods for personal or religious reasons?
If Yes what? ____

Emotional Health:

Please explain any major changes in your child's life (i.e. birth of a sibling, death in the family, divorce) in the past year.

____

____

Parent Information:

☐ No ☐ Yes Is there any accommodations or assistance your child needs in the classroom? (Adaptive equipment?)

____

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

____

____

____

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
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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 matriculado 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)** - *hecho por medio de actividades divertidas (evaluando áreas de lenguaje, destrezas motoras, cognitivas, socio-emocionales, y auto ayuda)*
❐	❐	**Behavioral Screening** *Evaluación de Comportamiento*	- **Done through parent and teacher observation as needed** - *Realiza 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)** - *hecho por medio de equipo autoacústico*
❐	❐	**Vision Screening** *Evaluación de la Vista*	- **done using a SPOT vision screening machine** - *hecho 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/guardián de*______________________________________,
(Child's name/*nombre del niño***)**

I give permission to Kennewick ECEAP or designated agencies to do all of 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/Guardián* **Date/***Fecha*

Washington State Department of CHILDREN, YOUTH & FAMILIES

ECEAP WELL CHILD EXAM

Kennewick School District
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CHILD INFORMATION: To be completed by parents Home Language ______________________

Child's Name____ Sex ☐M ☐ F Date of Birth__________________Age_________

Parents Name____Home Phone _________________

Address____City_______________________Zip __________

SCREENING TESTS: Required by ECEAP (to be completed by the Health Care Provider)

TEST	DATE	RESULTS
HEIGHT		
WEIGHT		
BLOOD PRESSURE		

PHYSICAL EXAMINATION/ASSESSMENT: Required by ECEAP (completed by Health Care Provider)

	NORMAL	ABNORMAL	NOT EVALUATED	COMMENTS
General Appearance				
Posture/Gait				
Head				
Skin				
Eyes				
Ears				
Nose/Throat				
Teeth/Mouth				
Heart				
Lungs				
Abdomen				
Muscular/Skeletal				
Neurological				

CHRONIC MEDICAL PROBLEMS: ☐Diabetes ☐Asthma ☐Seizures ☐Allergies (please list)____________________

☐Other_______________

RECOMMENDATIONS / Past Health History / Please list any abnormal blood tests or urinalysis.

GENERAL STATEMENT OF CHILD'S PHYSICAL STATUS:

Medications: _________________________________

☐ No Disability ☐ Physical Disability ☐Developmental Disability

____
Name of Clinic

____
Health Care Provider Signature

____
Today's Date

PLEASE RETURN COMPLETED FORM TO:

KENNEWICK SCHOOL DISTRICT
ECEAP OFFICE
1000 W. 4TH AVENUE
KENNEWICK, WA 99336
FAX: 509-222-5037