Agreement/Emergency Form

APPLE ECEAP – Arlington School District ☐ **Yellow** ☐ **Blue** ☐ **Green** **Orange**

Child's Name _____ Birth Date _____
Last First Middle

Address _____ City _____ State _____

Mother _____ Home # _____ Work # _____

Father _____ Home # _____ Work # _____

Email Address: _____

DO BOTH PARENTS LIVE IN THE SAME HOUSEHOLD? YES ☐ NO ☐
ARE BOTH PARENTS INVOLVED IN THE CHILD'S LIFE AT THIS TIME? YES ☐ NO ☐
ARE ANY MEMBERS OF THE FAMILY ACTIVE MILITARY? YES ☐ NO ☐ IF YES, WHAT BRANCH _____
HAS YOUR CHILD ATTENDED A SCHOOL DISTRICT OTHER THAN ARLINGTON? NO ☐ YES ☐, WHICH ONE _____

Read the following and initial each item to state you understand and give your approval. Not initialing means you do not approve.

YES	NO	I GIVE PERMISSION FOR MY CHILD TO HAVE
☐	☐	I understand Health and Developmental Screenings are a requirement of ECEAP. I am authorizing my child's participation in the screening process including: Completing development, social/emotional and health screenings and classroom observations conducted by the ECEAP staff and consultants. (Required by Performance Standards)
☐	☐	First Aid and/or emergency medical care including transportation by ambulance to the emergency room of an accredited hospital.
☐	☐	In the event that I cannot be contacted, I consent to medical, dental, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, dentist, or hospital when deemed necessary to safeguard my child's health.
☐	☐	To transport my child to and/or from the program, and on program field trips about which I have been notified in advance.
☐	☐	Tooth brushing after meals is a program requirement, I give permission for my child to use: ☐ Fluoridated ☐ Un-fluoridated ☐ Water only

YES	NO	I AGREE THAT
✔	☐	My child will receive immunizations as required by law BEFORE she/he begins school.
☐	☐	My child will have physical and dental examinations.
☐	☐	My child will have regular classroom attendance (85% required). I will call the school if absent.
☐	☐	For my child to be observed as part of classroom observations conducted for Early Achievers.
☐	☐	I understand that I have the right of access, review, and discussion on all information regarding my child with the appropriate staff person and/or consultant.

Other siblings: _____ / _____ _____ / _____
Name Birthdate Name Birthdate

_____ / _____ _____ / _____
Name Birthdate Name Birthdate

EMERGENCY INFORMATION

Insurance Provider _____ Group/Policy No. _____

Doctor's Name _____ Dentist's Name _____

Phone _____ Phone _____

Hospital Preference _____

Allergies such as bee stings, food, etc. _____

Allergies to medications? ☐ NO ☐ YES If yes, please list _____

Ongoing medical/health concerns? _____

Currently taking medication? ☐ NO ☐ YES If yes, please list medication, diagnosis, dosage:

_____

Arlington ECEAP Pick-Up List

You must have at least one other person and phone number outside of home.

Other than you, who else has permission to pick up your child?
(Please, also include emergency contact people, spouse or significant other.)

NAME _____ RELATIONSHIP _____

PHONE _____ ADDRESS _____

DATE ADDED _____

NAME _____ RELATIONSHIP _____

PHONE _____ ADDRESS _____

DATE ADDED _____

NAME _____ RELATIONSHIP _____

PHONE _____ ADDRESS _____

DATE ADDED _____

NAME _____ RELATIONSHIP _____

PHONE _____ ADDRESS _____

DATE ADDED _____

CUSTODY CONCERN

If custody concern is in regard to a biological parent we **must** have court papers on file.

NAME: _____

RELATIONSHIP : _____

ADDRESS: _____

Do you have legal paperwork for custody issue? Yes ☐ No ☐

This form was completed by:

_____ _____

Signature Date

2024 Health Information

Name: Gender: Grad Yr/Grade Other ID

Save | Save and Print | Back

ARLINGTON SCHOOL DISTRICT #16
315 N French Ave, Arlington, WA 98223
http://www.asd.wednet.edu

2023 - 2024 Health Information

For Office Use Only: *Completed Medication Orders* ☐ *Medical Supplies Received* ☐ *Medications Received* ☐

This information is needed to plan an appropriate program for your student and to prepare for any emergency situation, if one should arise. Your building nurse will contact you if there are any additional questions. This form is to be completed by the parent/guardian. **The law requires that life threatening conditions such as anaphylaxis, asthma, diabetes, or seizures have a completed care plan, completed medication orders, medical supplies and medication(s) supplied to the school prior to the student's first day of school. Please contact the building nurse as soon as possible to ensure the paperwork is complete.**

Does your child have any current health conditions? No

Medical History *(Indicate all that apply)*

Life Threatening Health Condition *(please contact nurse for care plan)*

- ☐ *Hemophilia
- ☐ *Anaphylactic Condition (EpiPen)
- ☐ *Asthma
- ☐ *Cardiac Condition
- ☐ *Diabetes Type I
- ☐ *EpiPen prescribed
- ☐ *Seizure Condition

Please explain:

Cardio Vascular

☐ Please explain:

Hematology (Blood)

- ☐ Sickle Cell Anemia
- ☐ Other blood condition, explain

Endocrine, Allergy, Immune System

- ☐ Food Allergy — List Allergy:
- ☐ Insect Allergy — List Allergy:
- ☐ Cystic Fibrosis
- ☐ Thyroid Disease
- ☐ Diabetes Type II

Other:

Gastrointestinal-Intestinal, Dental & Oral Conditions

- ☐ Celiac Disease
- ☐ Lactose Intolerance
- ☐ Irritable Bowel
- ☐ Oral Condition
- ☐ Crohn's
- ☐ Gastroesophageal Reflux
- ☐ Liver Disease
- ☐ Dental Condition

Other:

Skin & Subcutaneous Tissue

- ☐ Contact Dermatitis
- ☐ Eczema

Other:

Nervous System

- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Migraines
- ☐ Sensory Condition
- ☐ Speech Impairment
- ☐ Spinal Cord Injury
- ☐ ADHD/ADD diagnosed by:
- ☐ Recent Concussion — Date of concussion:

Concussion diagnosed by:

- ✔ Traumatic Brain Injury
- ✔ Developmental Disability
- ✔ Headaches
- ✔ Paralysis
- ✔ Shunt
- ☐ Spina Bifida

Other:

Mental or Behavioral Health Condition

- ☐ Sleep Disorder
- ☐ Anxiety
- ☐ Depression

Other:

Respiratory

- ☐ Reactive Airway Disease

Other:

Musculoskeletal & Connective Tissue

- ☐ Juvenile Rheumatoid Arthritis
- ☐ Muscular Dystrophy

Other:

Renal & Genitourinary

- ☐ Chronic Urinary Tract Infection
- ☐ Dysmenorrhea (painful periods)
- ☐ Incontinence

Other:

Neoplasm (Cancer/Tumors)

Please explain:

Eye & Ear

- ☐ Visually Impaired
- ☐ Hearing Impaired
- ☐ Chronic Ear Infections
- ☐ Wears Glasses/Contacts
- ☐ Wears Hearing Aids

Other:

MEDICATIONS: (Please report all medications that your student takes both at home and at school)

Is medication needed at home?	No	Please list:	fbjebjb
Is medication needed at school?	No	Please list:	ds jaB DKAS

State law requires written permission from parent/guardian and a licensed health care provider before any medications, prescription, or over-the-counter medication, may be taken at school. Forms are available from the school health rooms, school office, or from the Arlington Public Schools website at www.asd.wednet.edu/for_parents/district_forms.

If parent/guardian or authorized emergency contact cannot be reached at the time of a medical emergency, and if immediate care is urgent in the judgement of the school authorities, I authorize and direct the school authorities to send the student to the hospital or doctor most accessible. I understand that I will assume full responsibility for the payment of any services rendered. I understand that the information given above will be shared with appropriate school staff that needs to know in order to provide for the health and safety of my student.

I give permission to my child's school to add immunization information into the Immunization Information System to help the school maintain my child's record.

Parent/Guardian Name		Parent/Guardian's Electronic Signature		Date
Parent/Guardian Name		Parent/Guardian's Electronic Signature		Date

Washington State Department of CHILDREN, YOUTH & FAMILIES

Snohomish County

Snohomish County ECEAP

Health and Nutrition History Form

Child's Health History **Today's date:**_____

Child's name _____ Child's birthdate _____

Child's medical provider_____Location_____Phone_____

1. Were there any concerns during pregnancy or birth? ☐ Yes ☐ No If yes, please explain _____
2. Has your child ever had surgery or been hospitalized? ☐ Yes ☐ No Date/reason_____

3. Has your child had any of the following?	**Yes**	**No**	**If yes, please describe:**
a. Medically diagnosed with asthma?	☐	☐	
b. Any other breathing concerns?	☐	☐	
c. Any life-threatening allergies?	☐	☐	
d. Seizures/other neurological issues?	☐	☐	
e. Heart/other cardiovascular issues?	☐	☐	
f. Diabetes or other endocrine concerns?	☐	☐	
g. Bone or joint issues?	☐	☐	
h. Eczema or skin issues?	☐	☐	
i. Frequent ear infections or tubes?	☐	☐	
j. Other ear, nose, or throat concerns?	☐	☐	
k. Any lead exposure?	☐	☐	
l. Bladder, bowel/urinary tract concerns?	☐	☐	
m. Frequent, heavy nosebleeds?	☐	☐	
n. Serious injury or abuse?	☐	☐	
o. Second-hand smoke exposure?	☐	☐	
p. Behavior concerns?	☐	☐	
q. Other, please describe:	☐	☐	

For ECEAP staff: Enter all chronic health conditions, allergies, and medications into ELMS.

***Conditions in bold text above should be entered into ELMS as Life-Threatening. Alert ECEAP Nurse.**

Washington State Department of CHILDREN, YOUTH & FAMILIES

Snohomish County

Snohomish County ECEAP

MEDICATION

4. Does your child take medication on a regular basis? ☐ Yes ☐ No Reason(s) _____

5. Name of medication(s) and when taken: _____

6. Will your child need to take medications while at ECEAP? ☐ Yes ☐ No

_____

ALLERGIES

7. Does your child have allergies or severe reactions (including intolerances) to food, medicine, insects, animals or other substances? ☐ Yes-- please answer questions 12-15. ☐ No-- please skip to Dental History

8. Please name what your child is allergic to and describe your child's allergic reaction: _____

_____

9. How do you treat your child's allergy at home? _____

10. Has this allergy been diagnosed by a licensed healthcare provider? ☐ Yes ☐ No

11. Do you have epinephrine or any prescription medication at home to treat your child's allergy? ☐ Yes ☐ No

12. Additional information about allergies: _____

_____

DENTAL HISTORY

13. Name of your child's dentist _____ Phone _____

Date of last Dental Exam, if known _____

14. How would you rate your child's dental health? ☐ Good ☐ Fair ☐ In need of dental care

15. Do you have any concerns about your child's gums and/or teeth? ☐ Yes ☐ No If yes, please describe

_____

16. Does your child complain about tooth or mouth pain? ☐ Yes ☐ No If yes, describe _____

17. Do you have any family dental concerns? ☐ Yes ☐ No If yes, please describe _____

_____

PARENT/FAMILY

18. Do you have any concerns about your child's vision? ☐ Yes ☐ No If yes, describe _____

19. Do you have any concerns about your child's hearing? ☐ Yes ☐ No If yes, describe _____

20. Do you have any concerns about your child's speech? ☐ Yes ☐ No If yes, describe _____

21. Do you have any concerns about your behavior? ☐ Yes ☐ No If yes, describe _____

22. Do you have any concerns about your child's development? ☐ Yes ☐ No If yes, describe _____

23. Do you think your child may have been exposed to lead? ☐ Yes ☐ No If yes, how? _____

24. Do you have any challenges getting to the doctor or dentist? ☐ Yes ☐ No For example: Time, job schedule, transportation, insurance, etc. If yes, please describe _____

25. Is there any additional information you think is important for ECEAP staff to know about your child?

_____

_____

Washington State Department of CHILDREN, YOUTH & FAMILIES

Snohomish County

Snohomish County ECEAP

NUTRITIONAL INFORMATION

Yes	No	Please answer the following
✔	✔	Does your family receive WIC services?
✔	✔	Is there any food or drink that your child should not eat for cultural, religious, or medical reasons (other than allergies)? If yes, please explain:
✔	✔	Do you have any concerns about your child's eating habits? If yes, please explain.
✔	✔	Does your child eat non-food items (ex. paper, dirt, crayons, Play-Doh)? Please list:
✔	✔	Has there been a change in your child's appetite in the past month? If yes, please explain.
✔	✔	Is your child on a special diet? If yes, please explain.
✔	✔	Does your child have any problems with chewing or swallowing? If yes, please explain.
✔	✔	Do you have any concerns about how your child is growing? Please explain.
✔	✔	Does your child take a vitamin? How often?
✔	✔	Does your child take a prescribed iron supplement? Why? How often?
✔	✔	Does your child currently use any nutritional supplements (Pediasure, Ensure, herbs, etc.)? If yes, what, how often, for what reason? Please explain.
✔	✔	Do you share meals together as a family?
✔	✔	Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.

WOULD YOU LIKE MORE INFORMATION ABOUT:

✔ Picky eater	✔ Healthy eating on a budget	☐ Feeding young children
✔ Eating for a healthy weight	✔ Healthy snack ideas	☐ Healthy portion sizes
✔ Physical activity ideas	✔ Eating vegetables	☐ Eating meals as a family
✔ Limiting screen time	✔ Healthy beverages	☐ Food resources for your family

Parent/Guardian Signature:_____ Date:_____

Reviewed by parent/guardian for returning student: Initial _____ Date_____

Washington State Department of CHILDREN, YOUTH & FAMILIES

Snohomish County

Snohomish County ECEAP

Form: WELL CHILD CHECK

APPLE/ ECEAP Preschool

Child: _____ Birthdate ____/____/____

PLEASE DO NOT SEND A COPY OF CHILD'S MEDICAL RECORD. COMPLETE THIS FORM ONLY.

Date of exam:	Height:	Weight:	BMI:	Hearing: Vision:
Comprehensive EPSDT exam completed (please circle one): 3 year 4 year 5 year			Next exam due:	
Immunizations given this visit: (Please attach CIS or COE form)				
Fluoride prescribed? (Circle) YES NO	Anemia screening completed? _____ Yes _____ Not recommended		Lead screening completed? _____ Yes _____ Not recommended	

YES	NO	HEALTH STATUS
		Are you serving as this child's primary health care provider?
		Is this child up to date on an age-appropriate schedule of preventative and primary health care?
		Are immunizations up to date for this child?
		Is this child diagnosed as needing medical treatment for any of the following: (If yes, please note any recommendations or restrictions in comments section below.)
		Does this child have any severe allergies or chronic health conditions?
		Are there any life-sustaining medications prescribed for this child?
		Vision or hearing concerns?
		Developmental or growth concerns?
		Nutrition concerns?
		Dental concerns?
		Was child treated for any of the above listed conditions?

Provider comments:	
Provider signature:	Date:

APPLE/ ECEAP ARLINGTON- FAX #360-618-6293 PHONE # 360-618-6434

August 2019

WASHINGTON STATE Department of Children, Youth, and Families

Snohomish County ECEAP

Snohomish County

Dental Screening Form

APPLE/ECEAP PRESCHOOL

Child's Name: _____ Birth Date: _____

Received a dental exam on: _____

Dental Services Included:

_____ Visual exam

_____ Ride in chair and introduction to dental procedures

_____ Prophylaxis

_____ Flouride application

x-rays:

_____ Not indicated

_____ Were taken

_____ Treatment done (restoration, pulptherapy, extractions)

Exam Results Indicated:

_____ No problem

_____ Treatment needs (restoration, pulptherapy, extractions)

_____ Stronger emphasis on home oral hygiene

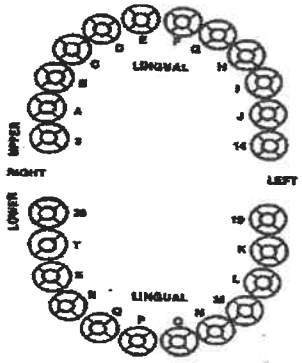
_____ Developmental problems

_____ Help with dietary problems

_____ Routine recall visit

Comments: _____

Treatment Plan:
Oral Conditions Before Treatment:



Summarized Treatment Completed and Needs

Tooth # or Letter	Surfaces	Description of Work	Date Service Performed Mo	Day	Yr

Approximate number of visits needed to complete treatment: _____

Next appointment scheduled for: _____

Dentist's Signature: _____ Date Signed: _____

Clinic Name: _____

Address: _____ Telephone Number: _____

Please return this form to:
APPLE/ECEAP ARLINGTON – **FAX # 360-618-6293**
Phone #360-618-6434

APPLE ECEAP PARENT INVOLVEMENT SURVEY

Parent/Guardian Name(s)_____Date_____

We plan yearly activities around your schedules and interests. Please complete the following survey so that we can offer activities that your family will enjoy.

Please check any areas in which you are interested in volunteering in:

- ☐ Preparation of activities for the children
- ☐ Preparation of Parent Café activities
- ☐ Preparation of Family Night activities
- ☐ Helping on Field Trips
- ☐ Working with the students during Center Time
- ☐ Helping with Small Groups
- ☐ Help on playground
- ☐ Reading a story
- ☐ Helping with a class Cooking Project
- ☐ Event meal planning
- ☐ Newsletter
- ☐ APPLE ECEAP Preschool Parent Advisory Committee
  - ☐ President
  - ☐ Vice President
  - ☐ Secretary
- ☐ Snohomish County Parent Advisory Committee
- ☐ Advocacy Day participant in Olympia

Are you interested in any other volunteer opportunities?

_____

If you have any knowledge, education, skills, or talents you are willing to share with students or other parents, please tell us about it.

_____

_____

Please check off all of the meeting topics you are interested in:

- ☐ Effective Family Communication
- ☐ Positive Discipline
- ☐ Stress Management
- ☐ Promoting Self-Esteem
- ☐ Child Development
- ☐ Parenting Skills
- ☐ Quick & Healthy Meals
- ☐ Meals on a Budget
- ☐ Nutritious & Fun Snacks
- ☐ Meal Planning
- ☐ Walking Group
- ☐ Gardening
- ☐ Photography
- ☐ Exercise Group
- ☐ Scrapbooking
- ☐ Crafting
- ☐ Developing Leadership Skills
- ☐ Disaster Preparedness
- ☐ Credit/Debt Management
- ☐ Multicultural Awareness
- ☐ First Aid/CPR
- ☐ Child Abuse/Neglect Prevention

Other topics of interest _____

Parent Café is usually from 12:00 PM to 1:30 PM. Will this time work for you? If not, what times are you available?_____

Arlington ECEAP Preschool

FAMILY RESOURCE SURVEY

Child's Name: _____ Parent's Name(s): _____

We find that parents are resourceful in meeting their family's needs. If there are areas where we could provide you with information or assistance, please place a check or X on the line next to that topic.

IMMEDIATE CONCERNS	Date Completed
☐	Food
☐	Clothing
☐	

HOUSING	Date Completed
☐	Low Income Housing
☐	PUD/PSE Discount
☐	Weatherization
☐	Energy Assistance

SUPPORT	Date Completed
☐	Parenting Information
☐	Coping with Divorce
☐	Coping with loss
☐	Abuse/Domestic Violence
☐	Drug/Alcohol Abuse
☐	Budgeting Information

OTHER RESOURCES	Date Completed
☐	Voter Registration
☐	Library Card Application
☐	Kinship Care Assistance
☐	Childcare Assistance & Referral
☐	
☐	

MEDICAL/ DENTAL SERVICES	Date Complete
☐	Apply for Health Insurance
☐	Finding a doctor
☐	Finding a dentist
☐	Counseling
☐	Mental Health Support Services
☐	Family Planning
☐	Quit Smoking
☐	

NUTRITION & FITNESS	Date Completed
☐	Healthy Eating Information
☐	WIC
☐	Youth Sports & Activities
☐	Local Parks

EDUCATION & EMPLOYMENT	Date Completed
☐	College/Financial Aid
☐	Job Search /Resume Help
☐	GED Classes
☐	ESL Classes

LEGAL SERVICES	Date Completed
☐	Divorce/Child Support
☐	General Legal Advice
☐	Landlord/Tenant Issues

Is there anything else you would like to share that would help us assist your family better?	
☐	Yes - we can talk during registration
☐	No

Follow-up:

Date_____ Parent Initials _____ Staff Initials _____

Date_____ Parent Initials _____ Staff Initials _____

Date_____ Parent Initials _____ Staff Initials _____

ARLINGTON Public Schools

To complete this form electronically, it must be opened in *Adobe Reader!*

Reset Form

USE OF STUDENT INFORMATION

Student's Full Name *(please print clearly)*

Most information about our students is confidential and cannot be made public without having consent of parents/guardians. However, the Federal Family Educational Rights and Privacy Act (FERPA) permits a school district to release "directory information" about a student unless a parent/guardian files this written objection form with the school office.

Arlington Public Schools identifies as directory information the student's name, photograph, address, telephone number, email address, date and place of birth, dates of attendance, grade in school, graduation year, participation in officially recognized activities and sports, weight/height of members of athletics teams, diplomas and awards received, and the most recent school attended by the student. Student work may also be published or released unless the parent or guardian has objected below. Directory information is not released for commercial purposes.

If you **DO NOT** want your child's directory information and/or student work to be published or released, please mark the category(ies) below for which you object to its release. Sign and date below and turn this form in to the office at your child's school:

☐ MILITARY	☐ HIGHER EDUCATION	☐ PUBLIC	☐ DISTRICT	☐ LOCAL
Military	***Higher Education***	***Broad Public Audience Beyond School Families***	***Internal Use Only***	***School Families are the primary audience, but accessible by general public.***
Examples include, but are not limited to: > Army > Air Force > Navy > Coast Guard	Examples include, but are not limited to: > Colleges > Technical Schools > Trade Schools	Examples include, but are not limited to: > Newspapers & Other Media > Publications to General Public > Other Agencies' Websites or Publications > Child's Former Teachers	Examples include, but are not limited to: > Signs/Posters in District Bldgs > Videos Used in School/District	Examples include, but are not limited to: > Yearbooks > Rosters > Programs > Newsletters to School Families > District Website > Family Handbook > For release to District/School-selected vendors and event planners like photographers, trip organizers, alumni assoc.

These instructions will remain in effect until revised by a parent/guardian, however, it is recommended, if you have objections to the release of your child's directory information and/or student work, that you complete a new form each school year as definitions, categories, or laws may have changed.

I HEREBY REQUEST THAT MY CHILD'S DIRECTORY INFORMATION AND STUDENT WORK **NOT BE PUBLISHED OR RELEASED** FOR THE CATEGORIES I HAVE MARKED ABOVE.

Parent/Guardian Signature

Date

Adopted: 08/12
Revised: 12/13

Snohomish County Early Childhood Education and Assistance Program

Consent for Release of Information

Child's Name: _____ Date of Birth: _____

Site: APPLE ECEAP

Directions: Obtain parent/guardian signature for ONLY ONE consent/release section per form.

☒ **Consent for use of Photographs and Videos** (check only one box per form)
I give consent for images of my child to be used in publications and media for and by ECEAP, including program newsletters, web sites, recruitment materials, and event flyers.

☐ **General Release of Confidential Information** (check only one box per form)
I authorize ECEAP staff to release information to school district personnel including kindergarten staff to facilitate my child's transition to kindergarten.

Person to release information to: _____ Contact information: _____

Type of information to be released: _____

Reason for release information: _____

☐ **Release of Confidential Information for program use** (check only one box per form)
I authorize ECEAP staff to publish my contact information to create a classroom or program directory. Information to be published includes:

Name: _____ Child's Name: _____

Occupation: _____

Address: _____

Home phone: _____ Work Phone: _____

Email: _____

☐ **Release of Confidential Information to Service Providers** (check only one box per form)
I authorize ECEAP staff to give out the names, address and ages of my family members to agencies, churches or others for the purpose of receiving services such as holiday gifts, donations and other services.

Names of Agencies/Programs/Organizations: _____

In accordance with the requirements of the Family Educational Rights and Privacy Act of 1974, and the ECEAP Performance Standard PAO-4, information sent or received by ECEAP may not be shared with any other party without the written consent of the parent or guardian.

Parent /Guardian Signature	**ECEAP Staff Signature**	**Date**
Date	**ECEAP Staff Signature**	**Date**

This form is valid for (12 months or sooner): ☐ **12 months** ☐ **until** _____. (Check one box)

Snohomish County Early Childhood Education and Assistance Program

Prevention of Child Abuse and Neglect Training
ECEAP Parent/Community Volunteer Statement

Name of Parent/Community Volunteer _____ ECEAP Site _____

Date of Training _____

I understand that Early Childhood Education and Assistance Program (ECEAP) staff members are mandated reporters. As mandated reporters, staff must report all suspicions of possible child abuse or neglect to the proper authorities immediately.

As an ECEAP Parent/Community Volunteer:

- I understand that I am not a mandated reporter. However, if I suspect that a child is being abused or neglected, I should report all evidence of possible abuse or neglect to ECEAP staff the same day, including a written report with important and relevant facts that I observed or the child reported. ECEAP staff will then report the information to proper authorities as required by State law and school district/agency policies.

- I understand that **ALL INFORMATION ABOUT POSSIBLE CHILD ABUSE OR NEGLECT IS CONFIDENTIAL**. I may not discuss child abuse or neglect situations with anyone except for reporting the information to ECEAP staff or when asked by proper authorities (CPS or law enforcement) investigating the abuse or neglect. This confidentiality means I may not discuss abuse and neglect situations with my family members, neighbors, or anyone else.

As a volunteer in ECEAP, I acknowledge that I have received the above training about preventing child abuse and neglect. I will abide by the above guidelines.

Signature of Parent/Community Volunteer _____ Date _____

Signature of ECEAP staff that provided training _____ Date _____

ARLINGTON
Public Schools

Washington State Patrol Identification and Criminal History Record Request

WASHINGTON STATE PATROL
Request for Conviction Criminal History Record (RCW 10.97)

Instructions: Please complete Section A and return the form to the school office to be processed. This form must be completed and returned to the office no less than two (2) week prior to the activity for which the request is being made.

Note: The school district will conduct a records search using the Washington State Patrol Criminal History database. The results are furnished solely on the basis of name and/or description similarity with the subject information provided. Additional information (which may include a thumbprint) may be necessary for positive identification or non-identification.

(A) Subject Information

Last Name of Applicant | First Name | Middle Name

Alias/Maiden name

Date of birth | Gender | Race | Daytime Phone Number

Student Name | School

Reason (i.e.: volunteer at school, field trip, event, etc.)

I authorize Arlington Public Schools to conduct a criminal background check for me through the Washington State Patrol system.

Applicant's Signature | Date

(B) Requestor Information (SCHOOL USE ONLY)

Carrie Saunders
Name of Requestor

APPLE ECEAP Preschool Program Manager
Title

Arlington Public Schools

APPLE Preschool/Eagle Creek Elementary
School/Department

1215 E Fifth Street
Address

Arlington, WA 98223

Carrie Saunders
Requestor's Signature

Received _____ Initials

Search conducted _____ Initials

☐ Record is clear ☐ Record is **not** clear

Principal Approval Rec'd *(if applicable)* _____ Initials

Supt. Approval Rec'd *(if applicable)* _____ Initials

☐ Approved ☐ Denied

Valid Until* _____

*Generally 2 years from the date of this search.

Applicant notified *(if denied)* _____ Initials

Posted to Skyward *(if approved)* _____ Initials

Student Name: _____ Grade: Pre-K School: APPLE Send Copy to EL Coordinator if Applicable

Washington State Ethnicity and Race Data Collection Form

School districts in Washington State are required to report student data by ethnicity and race categories to the state's Office of Superintendent of Public Instruction (OSPI). Ethnicity and race categories are set by the federal government, the Washington State Legislature, and OSPI. If parents, guardians, or students do not provide ethnicity and race information, districts are responsible for assigning categories based on observation. Please select both ethnicity and race. Hispanic Yes or No, if yes select which one(s). Then select any race(s) that may apply. Be sure to notice the bold categories prior to selecting the race(s).

ETHNICITY

Hispanic: ☐ Yes ☐ No (H01)

Hispanic

☐ Hispanic (H00)	☐ Cuban (H09)	☐ Mestizo (H17)	☐ Salvadoran (H24)
☐ Argentine (H02)	☐ Dominican (H10)	☐ Native (H18)	☐ Spaniard (H25)
☐ Bolivian (H03)	☐ Ecuadorian (H11)	☐ Nicaraguan (H19)	☐ Surinamese (H26)
☐ Brazilian (H04)	☐ Guatemalan (H12)	☐ Panamanian (H20)	☐ Uruguayan (H27)
☐ Chicano (Mexican American) (H05)	☐ Guyanese (H13)	☐ Paraguayan (H21)	☐ Venezuelan (H28)
☐ Chilean (H06)	☐ Honduran (H14)	☐ Peruvian (H22)	☐ _____
☐ Colombian (H07)	☐ Jamaican (H15)	☐ Puerto Rican (H23)	Hispanic/Latino Write In (H29)
☐ Costa Rican (H08)	☐ Mexican (H16)		

RACE-NATIVE HAWAIIAN/OTHER PACIFIC

Native Hawaiian/Other

☐ Native Hawaiian/Other Pacific Islander (P00)

Pacific Islander

☐ Carolinian (P01)	☐ Maori (P07)	☐ Pohpeian (P13)	☐ Tongan (P18)
☐ Chamorro (P02)	☐ Marshallese (P08)	☐ Samoan (P14)	☐ Tuvaluan (P19)
☐ Chuukese (P03)	☐ Native Hawaiian (P09)	☐ Solomon Islander (P15)	☐ Yapese (P20)
☐ Fijian (P04)	☐ Ni-Vanuatu (P10)	☐ Tahitian (P16)	☐ _____
☐ I-Kiribati/Gilbertese (P05)	☐ Palauan (P11)	☐ Tokelauan (P17)	Pacific Islander Write In (P21)
☐ Kosraean (P06)	☐ Papuan (P12)		

RACE-BLACK/AFRICAN-AMERICAN

Black/African

☐ Black/African-American (B00)	☐ African American (B01)	☐ African Canadian (B02)	☐ _____ Black Write In (C02)

Caribbean

☐ Anguillan (B03)	☐ Caymanian (Cayman Island) (B09)	☐ Grenadian (B13)	☐ Jamaican (B18)
☐ Antiguan (B04)	☐ Cuba Dominican (B10)	☐ Guadeloupian (B14)	☐ Martiniquais/Martiniquaise (B17)
☐ Bahamian (B05)	☐ Dominican (Dominican Republic) (B11)	☐ Haitian (B15)	☐ Montserratian (B18)
☐ Barbadian (B06)	☐ Dutch Antillean (Netherlands Antilles) (B12)		☐ Puerto Rican (B19)
☐ Barthélemois/Barthélemoises (Saint Barthélemy) (B07)			☐ _____
☐ British Virgin Islander (B08)			Caribbean Write In (B20)

Central African

☐ Angolan (B21)	☐ Congolese (Rep. of the Congo) (B25)	☐ São Toméan (B29)
☐ Cameroonian (B22)	☐ Congolese (Democratic Republic of the Congo) (B26)	☐ Principe (B30)
☐ Central African (Central African Rep.) (B23)	☐ Equatorial Guinean (B27)	☐ _____
☐ Chadian (B24)	☐ Gabonese (B28)	Central African Write In (B31)

East African

☐ Burundian (B32)	☐ Malagasy (Madagascar) (B38)	☐ Rwandan (B44)	☐ Tanzanian (United Republic of Tanzania) (B50)
☐ Comoran (B33)	☐ Malawian (B39)	☐ Seychellois/Seychelloise (B45)	☐ Zambian (B51)
☐ Djiboutian (B34)	☐ Mauritian (Mauritius) (B40)	☐ Somali (B46)	☐ Zimbabwean (B52)
☐ Eritrean (B35)	☐ Mahoran (Mayotte) (B41)	☐ South Sudanese (B47)	☐ _____
☐ Ethiopian (B36)	☐ Mozambican (B42)	☐ Sudanese (B48)	East African Write In (B53)
☐ Kenyan (B37)	☐ Reunionese (B43)	☐ Ugandan (B49)	

Latin American

☐ Argentine (B54)	☐ Ecuadorian (B61)	☐ Mexican (B68)	☐ Uruguayan (B75)
☐ Belizean (B55)	☐ El Salvadoran (B62)	☐ Nicaraguan (B69)	☐ Venezuelan (B76)
☐ Bolivian (B56)	☐ Falkland Islander (B63)	☐ Panamanian (B70)	☐ _____
☐ Brazilian (B57)	☐ French Guianese (B64)	☐ Paraguayan (B71)	Latin American Write In (B77)
☐ Chilean (B58)	☐ Guatemalan (B65)	☐ Peruvian (B72)	
☐ Colombian (B59)	☐ Guyanese (B66)	☐ S. Georgia/S. Sandwich Islands (B73)	
☐ Costa Rican (B60)	☐ Honduran (B67)	☐ Surinamese (B74)	

South African

☐ Botswanan (B78)	☐ Namibian (B80)	☐ Swazi (B82)	
☐ Mosotho (Lesotho) (B79)	☐ South African (B81)	☐ _____	
		South African Write In (B83)	

West African

☐ Beninese (B84)	☐ Gambian (B89)	☐ Mauritanian (B93)	☐ Senegalese (B97)
☐ Bissau-Guinean (B85)	☐ Ghanaian (B90)	☐ Nigerien (Niger) (B94)	☐ Sierra Leonean (B98)
☐ Burkinabé (Burkina Faso) (B86)	☐ Liberian (B91)	☐ Nigerian (Nigeria) (B95)	☐ Togolese (B99)
☐ Cabo Verdean (B87)	☐ Malian (B92)	☐ Saint Helenian (B96)	☐ _____
☐ Ivorian (Cote d'Ivoire) (B88)			West African Write In (B01)

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RACE-AMERICAN INDIAN/ALASKAN NATIVE

American Indian/Alaskan

- ☐ American Indian/Alaskan Native (N00)
- ☐ _____ Alaska Native Write In (N36)
- ☐ _____ American Indian Write In (N37)

Washington State Tribes

- ☐ Chinook Tribe (N01)
- ☐ Confederated Tribes and Bands of the Yakama Nation (N02)
- ☐ Confederated Tribes of the Chehalis Reservation (N03)
- ☐ Confederated Tribes of the Colville Reservation (N04)
- ☐ Cowlitz Indian Tribe (N05)
- ☐ Duwamish Tribe (N06)
- ☐ Hoh Indian Tribe (N07)
- ☐ Jamestown S'Klallam Tribe (N08)
- ☐ Kalispel Indian Community/Kalispel Reservation (N09)
- ☐ Kikiallus Indian Nation (N10)
- ☐ Lower Elwha Tribal Community (N11)
- ☐ Lummi Tribe of the Lummi Reservation (N12)
- ☐ Makah Indian Tribe/Makah Indian Reservation (N13)
- ☐ Marietta Band of Nooksack Tribe (N14)
- ☐ Muckleshoot Indian Tribe (N15)
- ☐ Nisqually Indian Tribe (N16)
- ☐ Nooksack Indian Tribe of Washington (N17)
- ☐ Port Gamble S'Klallam Tribe (N18)
- ☐ Puyallup Tribe of Puyallup Reservation (N19)
- ☐ Quileute Tribe of the Quileute Reservation (N20)
- ☐ Quinault Indian Nation (N21)
- ☐ Samish Indian Nation (N22)
- ☐ Sauk-Suiattle Indian Tribe of Washington (N23)
- ☐ Shoalwater Bay Indian Tribe/Shoalwater Bay Indian Reservation (N24)
- ☐ Skokomish Indian Tribe (N25)
- ☐ Snohomish Tribe (N26)
- ☐ Snoqualmie Indian Tribe (N27)
- ☐ Snoqualmoo Tribe (N28)
- ☐ Spokane Tribe of the Spokane Reservation (N29)
- ☐ Squaxin Island Tribe of the Squaxin Island Reservation (N30)
- ☐ Stillacoom Tribe (N31)
- ☐ Stillaguamish Tribe of Indians of Washington (N32)
- ☐ Suquamish Indian Tribe of the Port Madison Reservation (N33)
- ☐ Swinomish Indian Tribal Community (N34)
- ☐ Tulalip Tribes of Washington (N35)

RACE-ASIAN

Asian

- ☐ Asian (A00)
- ☐ Asian Indian (A01)
- ☐ Bangladeshi (A02)
- ☐ Bhutanese (A03)
- ☐ Burmese/Myanmar (A04)
- ☐ Cambodian/Khmer (A05)
- ☐ Cham (A06)
- ☐ Chinese (A07)
- ☐ Filipino (A08)
- ☐ Hmong (A09)
- ☐ Indonesian (A10)
- ☐ Japanese (A11)
- ☐ Korean (A12)
- ☐ Lao (A13)
- ☐ Malaysian (A14)
- ☐ Mien (A15)
- ☐ Mongolian (A16)
- ☐ Nepali (A17)
- ☐ Okinawan (A18)
- ☐ Pakistani (A19)
- ☐ Punjabi (A20)
- ☐ Singaporean (A21)
- ☐ Sri Lankan (A22)
- ☐ Taiwanese (A23)
- ☐ Thai (A24)
- ☐ Tibetan (A25)
- ☐ Vietnamese (A26)
- ☐ _____ Asian Write In (A27)

RACE-WHITE

White

- ☐ White (W00)
- ☐ _____ White Write In (W36)

Eastern European

- ☐ Bosnian (W01)
- ☐ Herzegovinian (W02)
- ☐ Polish (W03)
- ☐ Romanian (W04)
- ☐ Russian (W05)
- ☐ Ukrainian (W06)
- ☐ _____ Eastern European Write In (W07)

Middle Eastern and North African

- ☐ Algerian (W08)
- ☐ Amazigh or Berber (W09)
- ☐ Arab or Arabic (W10)
- ☐ Assyrian (W11)
- ☐ Bahraini (W12)
- ☐ Bedouin (W13)
- ☐ Chaldean (W14)
- ☐ Copt (W15)
- ☐ Druze (W16)
- ☐ Egyptian (W17)
- ☐ Emirati (W18)
- ☐ Iranian (W19)
- ☐ Iraqi (W20)
- ☐ Israeli (W21)
- ☐ Jordanian (W22)
- ☐ Kurdish Kuwaiti (W23)
- ☐ Lebanese (W24)
- ☐ Libyan (W25)
- ☐ Moroccan (W26)
- ☐ Omani (W27)
- ☐ Palestinian (W28)
- ☐ Qatari (W29)
- ☐ Saudi Arabian (W30)
- ☐ Syrian (W31)
- ☐ Tunisian (W32)
- ☐ Yemeni (W33)
- ☐ _____ Middle Eastern Write In (W34)
- ☐ _____ North African Write In (W35)

Parent/Guardian Signature _____ Date _____

FOR OFFICE USE ONLY: Received By _____ Date _____