Washington State Department of CHILDREN, YOUTH & FAMILIES

ECEAP Early Childhood Education & Assistance Program

2026-2027 ECEAP Prescreen & Application Combined

If you need help completing this form, please contact _____

Return completed form to _____

Section 1: Child Information

Legal first name _____

Middle name _____

Legal last name _____

Nickname _____

Date of birth _____

Gender identity _____

Is this child a member, or eligible for membership, of a Federally Recognized Tribe of the United States?

Yes No

General Information

IEP - Is this child on an Individualized Education Program (IEP)? ..... 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 tribal 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

Language

Child's first language_____

Child's second language_____

This child speaks *(Select one)*

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

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 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

Race and Ethnicity

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

Decline to report child's race Decline to report child's ethnicity

White **Black or African American**

Hispanic/Latino

- 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* _____

Alaska Native

- Aleut (Unangan)
- Alutiiq
- Athabaskan
- Eskimo (Inupiaq or Yupik)
- Eyak
- Haida
- Tlingit
- Tsimshian
- Other Alaska Native _____

Asian

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

American Indian

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

Native Hawaiian or Other Pacific

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

Section 2: Household Members

- Please list everyone living in the household who may be counted in the 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 and 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	**Yes**	**Yes**
		Parent/ Guardian_1	**Yes**	**Yes**
		Parent/ Guardian_2	**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 SMI 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.

Section 3: Family Contact Information

Contact 1

Name _____ Relationship to Child _____

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

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

Address _____ City _____ State **WA** ZIP Code _____
(Physical Address)

Address _____ City _____ State **WA** ZIP Code _____
(Mailing Address if different than physical address)

Email _____ Phone _____ Alternate Phone _____

Contact 2

Name _____ Birth date _____ Relationship to Child _____

Contact 3

Name _____ Birth date _____ Relationship to Child _____

Contact 4

Name _____ Birth date _____ Relationship to Child _____

Section 4: Child lives with

One parent/guardian (Name) _____ (*Skip to section* 5 i*f one parent)*

Two parents/guardians in same household

Parent/guardian name 1 _____

Parent/guardian name 2 _____

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 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 1 _____ Household 2 _____

Household 2

Relationship with child _____

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

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

Address _____ City _____ State _____ ZIP Code _____
(Physical Address)

Address _____ City _____ State _____ ZIP Code _____
(Mailing Address if different than physical address)

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 child care hours separately for two parents

Parent/Guardian # 1

Name _____ Employed Yes No *(if yes answer the following)*

Name of employer *(don't enter unknown or N/A)* _____

Average paid hours per week _____

In school or job training Yes No *(if yes answer the following)*

Class hours per week _____ Study hours per week *(maximum 10)* _____

Name of school or training organization _____

Goal or major _____

Travel between child care and work/school Yes No Hours per week *(maximum 10)* _____

CPS/FAR/ICW child care hours not counted above Yes No
Additional hours per week of child care approved by CPS) _____

Approved WorkFirst hours not counted above _____

Name of activity _____ Total hours per week _____

Disabled parent unable to work and unable to care for the child while the other parent works Yes No
If either parent has more than 55 hours total per week, explain:

Parent/Guardian # 2

Name _____ Employed Yes No *(if yes answer the following)*

Name of employer *(don't enter unknown or N/A)* _____

Average paid hours per week _____

In school or job training Yes No *(if yes answer the following)*

Class hours per week _____ Study hours per week *(maximum 10)* _____

Name of school or training organization _____

Goal or major _____

Travel between child care and work/school Yes No Hours per week *(maximum 10)* _____

CPS/FAR/ICW child care hours not counted above Yes No

Additional hours per week of child care approved by CPS) _____

Approved WorkFirst hours not counted above _____

Name of activity _____ Total hours per week _____

Disabled parent unable to work and unable to care for the child while the other parent works Yes No

If either parent has more than 55 hours total per week, explain:

Section 6: How did you find out about ECEAP

DCYF website
Community event
Flyer
ECEAP employee
Word of mouth
Caseworker
Media
Community agency - Name of agency _____
Other _____

Section 7: Survey for Statewide Planning

If you could choose the length of day for your child's preschool, which would be best for your child and family?
Please note, these options may not all be available in your community this year.

Part Day – about 3 hours, 3 or 4 days a week.
School Day – about 6 hours, 4 or 5 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:**
  please enter the case number _____ *(if none write none and skip to Section 10)*

- 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. Explain how basic needs are met.

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

Select one 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			$		$
	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			$		$
					Total	

Do you still receive the income above? Yes No If yes, *skip to section 10*

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

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

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

Section 10: Previous Enrollment

This child was previously enrolled in: *(check all that apply)*

Head Start at your agency
Head Start with a different agency
Migrant/Seasonal Head Start anywhere in WA
Early Head Start Name of EHS Grantee_____
Any birth to three home visiting program
Early ECEAP Name of Early ECEAP contractor_____
ECLIPSE - Early Childhood Intervention and Prevention Services
ESIT – Early Support or Infants Name of ESIT Provider _____
Part C Part C IDEA Early Intervention program in another state State _____
Name of provider _____
No previous early learning preschool enrollment

Section 11: IEP or Suspected Delay

(Check one if applicable)

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 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
Developmental delay	Orthopedic impairment	Traumatic brain injury
Emotional disturbance	Other health impairment	Visual 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: Behavior

Has this child been expelled from any early learning program or child care 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 ..... Yes No

(if yes select one)

Severely impacts their ability to engage in work, school, or family life?

Moderately impacts their ability to engage in work, school, or family life?

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 or seasonal agricultural worker? ..... Yes No

Does this child have a parent who 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 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 incarcerated, such as in jail or prison? ..... Yes No

Has this child experienced the loss of a parent or primary caregiver such as by death or abandonment? ..... Yes No

Has this child experienced the divorce or separation of their parents? ..... Yes No

Has this child experienced homelessness within the last 12 months? ..... Yes No

Has this child lived in a household with domestic violence, including in-utero? ..... Yes No

Has this child lived in a household with substance abuse, including in-utero? ..... Yes No

Has this family previously received support or been involved in tribal or state systems including CPS/FAR/ICW services, or comparable tribal service, or been involved with law enforcement/court system regarding child abuse, neglect, or sexual assault? ..... Yes No

Has this child been reunited with parents after foster or kinship care in the past 12 months? ..... Yes No

ECEAP received a professional referral for this family. ..... Yes No

Section 14: Parent Education Level

(select the highest level of education)

Parent/Guardian 1 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

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

Section 15: Health Information

Please attach a copy of the child's immunization record

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

- Severely impacts child development or attendance?
- Moderately impacts child development or attendance?

If yes, please describe

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

Does this child have medical insurance or coverage?

- Washington Apple Health for Kids/ Provider One Services Card
- Private Medical Insurance
- Military Coverage
- Tribal Coverage

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

Has ECEAP received a copy of the results for a well-child (EPSDT) exam? ..... Yes No

Date of last well-child exam before applying for ECEAP _____

Does this child have dental insurance or coverage?

- Washington Apple Health for Kids/ Provider One Services Card
- Military Coverage
- Private Dental Insurance
- Tribal Coverage
- ABCD (not available in all counties)

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

Has ECEAP received a copy of the results for a dental screening? ..... Yes No

Date of last dental screening before applying for ECEAP _____

Signature of Parent/Guardian

I promise that the information on this form is true and correct. I have authority to enroll this child and 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.
- Services that were not actually provided.
- Class start and end dates.
- Children's actual start dates and last days in class.
- A family providing false information in order to enroll in ECEAP.

Print Name _____ Title _____

Signature _____ Date _____

Voices of Tomorrow

Emergency Contact and Medical Insurance Information

Child Name:		DOB:
Home Address:	Zip code:	Home Language:
Parent/Guardian Name (Lives in Home ☐ Yes ☐ No):	Cell Phone:	
Email Address:	Work Phone:	
Parent/Guardian Name (Lives in Home ☐ Yes ☐ No):	Cell Phone:	
Email Address:	Work Phone:	

EMERGENCY CONTACTS/ AUTHORIZED PICK UP LIST

The primary adult will automatically be the first person we try to contact. Please supply additional emergency contacts below.

Name:	Phone:	Relationship to Child:
Name:	Phone:	Relationship to Child:
Name:	Phone:	Relationship to Child:

Medical and Insurance Information

WA Apple Care? ☐ Yes ☐ No Other Insurance:	Medical ID#:
Medical Plan Name:	Dental Plan Name:
Medical Clinic Name:	Phone:
Dental Clinic Name:	Phone:
Medical Condition(s)? ☐ Yes ☐ No (If YES, please see list on back)	
Medically diagnosed food/milk allergies? ☐ Yes ☐ No If YES, please list:	Food to Omit Due to Sensitivities/Religious Reasons:
Other allergies:	Does your child require an EpiPen Jr? ☐ Yes ☐ No
Current Medication(s):	Preffered Hospital:

In an emergency, Voices of Tomorrow has my permission to call an ambulance or take my child to any available physician or hospital at my expense and to obtain medical treatment for my child. In most emergencies, 911 is called and the child is transported to the nearest hospital.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Form Update Signature **Date**

Revised 7/9/2020

CITY OF SEATTLE - ECEAP-STEP AHEAD-HEADSTART

AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

AUTHORIZATION TO DISCLOSE RECORDS OF:

NAME LAST	FIRST	MIDDLE	DATE OF BIRTH

Medicaid ID # or other information:	PARENT/GUARDIAN NAMES

DISCLOSE TO: **(Completed by Program Staff)**

SITE/PROGRAM NAME

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL ADDRESS

REASON FOR DISCLOSURE

ECEAP/STEP AHEAD/EARLY HEAD START/HEAD START/ REGULATIONS

AUTHORIZATION

SOURCES: I authorize the mutual exchange of information about my child as described below. Information may be provided verbally or by computer data transfer, mail, fax, or hand delivery. (CIRCLE ALL THAT APPLY)

Provider:

ADDRESS:	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)

RECORDS: I authorize the following records be disclosed:

- ❒ EPSDT EXAM/TREATMENT
- ❒ DENTAL EXAM/TREATMENT
- ❒ HEALTH (DATED FROM _____ TO _____)
- ❒ DEVELOPMENTAL SCREENING
- ❒ IMMUNIZATION
- ❒ OTHER: _____

This authorization is valid for 90 days unless otherwise specified: _____.

I may revoke or withdraw my permission in writing at any time, but that will not affect information already disclosed.

- I understand that these records will be treated as confidential by the Head Start/Early Head Start/ECEAP/Step Ahead program.
- A copy of this form is valid to give permission to disclose records.
- Information disclosed through this authorization may be shared and is no longer protected by HIPAA.
- Authorizing the disclosure of this information is voluntary. I do not need to sign this form in order to assure treatment or payment.

PLEASE NOTE: **If confidential records include any of the following information, you must also complete the below section to allow disclosure of these records**.

SPECIAL RECORDS: I give my permission to disclose the following records (check all that apply):

- ❒ HIV/AIDS and STD test results, diagnosis or treatment records (RCW 70.24.105)
- ❒ Mental health records (RCW 71.05.620) including:_____
- ❒ Chemical Dependency (CD) records (42 CFR Part 2) including:_____

Notice to those receiving information: If these records contain information about HIV, STDs, or alcohol or drug abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.

AUTHORIZATION BY (SIGNATURE)	RELATIONSHIP TO CHILD	DATE SIGNED	TELEPHONE # (INCLUDE AREA CODE)

PRINT NAME	INTERPRETER (SIGN AND PRINT NAME, IF APPLICABLE)

If I am not the person who is the subject of the records, I am authorized to sign because I am the:

❒ Parent of minor ❒ Legal Guardian ❒ Other:_____

(See reverse side for instructions)

INSTRUCTIONS FOR COMPLETING
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Staff need to ensure that all areas are completed. Use N/A for sections that do not apply.

- **Authorization to Disclose Records** – Completed by staff or parent.
  Reason for disclosure is pre-printed on the form.

- **Disclose to** – Completed by ECEAP staff.
  Be sure to include the Medicaid identification number found on the medical coupon.

*If multiple providers are to be contacted, form may be photocopied at this point.

- **Authorization** – Completed by staff or parent. Separate form required for each provider.
  Check all records that apply.

- **Special records** – Complete only as needed.
  Note special disclosure conditions for this information.

- **Authorization/Signature** – Must be original on all forms.

Voices of Tomorrow – Subcontractor

Permission to Screen

As a participant in Voices of Tomorrow Preschool Program, your child will receive the following screenings:

1. Speech/Language
2. Hearing
3. Vision
4. Height and Weight
5. Developmental Screening – ASQ, ASQ-SE
6. Behavioral/Emotional Observation
7. Ongoing assessment and observation by educational staff
8. Head Lice check on all children a minimum of three times per year

These screenings will be provided by trained, certified, and/or licensed practitioners and/or clinically supervised interns from Voices of Tomorrow, and other community agencies.

It is the goal of Voices of Tomorrow to provide services to children that will enhance their growth and development. Each of these assessments assists in planning for your child's health and/or educational needs. You will receive information regarding the results of these screenings once they have been completed.

Thank you for your cooperation in helping us to reach these goals.

Child Name: _____

I give Voices of Tomorrow and their representative's permission to perform the above screenings.

Child Abuse and Neglect Policy: I have received a copy of Albina Head Start's Child Abuse and Neglect Policy and staff and parent information.

Parent Signature: _____ Date:_____

Revised 7/7/2020

Voices of Tomorrow General Consent Form

This Consent, Waiver, and Release is the entire agreement between our student/parent and Voices of Tomorrow, regarding the subject matter hereof and is governed by the laws of the State of Washington.					
Child's Name:	First	Middle	Last	Birthdate:	
Parent's Name:	First	Middle	Last	Phone or Cell Number:	
Photos and videos will be utilized as promotional advertisements for VOT Programs. Please circle either Yes or No Health – I have informed VOT staff that my child has or does not have allergy, medical, health concerns Yes or No					
Internal/External Photographs and Videos (Data Records; Outreach and Recruitment, Educational, etc.)*:*				Yes	No
External Social Media (*Website sites and online communities are created for networking and sharing information, ideas, education, etc.)*:				Yes	No
Field Trips – I understand and agree that neither Voices of Tomorrow Preschool, nor its trustees, representatives, instructors, or agents may be held liable in any way for any occurrence in connection with my child's participation in the Field Trip which may result in injury, harm or other damages to me or my family. You consent to your child's participation in all VOT's indoor/outdoor activities for educational purposes. I allow VOT to transport my child to and from locations upon signing bus wavier.					
Field Trips (Which could include public or private transportation; museums, public lakes and parks, theatrical performances, etc.):				Yes	No
I approve VOT to conduct health (vision, hearing, height, weight, and dental screenings.				Yes	No
Assessments and evaluations provide VOT with critical information in learning, teaching, and outcomes for the students and staff. VOT will then initialize the appropriate changes to assist in the growth of your child.					
Assessments and Evaluations				Yes	No
Data Sharing with the City of Seattle, SFSP, KCP, Tukwila School District, Highline School District. The ability to share the same data resource with multiple applications or users. The data is stored on one or more servers in the network and that there is some software locking mechanism that prevents the same set of data from being changed by two people at the same time. Data sharing is a primary feature of a database management. Example - student health development; support parent/child relationship; information of importance from Early Learning. **Parents give consent for names listed above to have access to student attendance and emergency contact info** provided to the school office					
Data Sharing:				Yes	No

As parent or legal guardian, I acknowledge and grant Voices of Tomorrow permission for my child _____ to participate in all the programs above.

Parent/Guardian Name: _____

Address: _____ City: _____ Zip: _____

Email Address: _____

I understand that it is my responsibility to update this form if I no longer wish to authorize one or more of the above programs. I agree that this form will remain in effect during the term of my child's enrollment.

_____ Date: _____

Signature of Parent or Guardian