



YES FOR EARLY SUCCESS COOPERATIVE

Parent/Guardian Consent Form for Child Health Screenings

INTRODUCTION / PURPOSE

YES for Early Success Cooperative is a community-driven organization dedicated to supporting children, families, and early learning programs across Washington State. In alignment with our mission to ensure **equitable access** to high-quality early education and our vision of a **collaborative network of empowered families and programs**, we prioritize partnerships that uplift family voices and choices. Our approach is grounded in principles of **Liberatory Design**—centering equity, collective liberation, self-awareness, and shifting power dynamics by involving and empowering families. We believe that families are experts on their children, and we strive to create processes that honor your voice and choice.

This consent form is designed to inform you about, and to seek your permission for, routine **health screenings** (vision, hearing, height, and weight) for your child. These screenings are conducted as part of our Early Childhood Education and Assistance Program (**ECEAP**) to support your child's health, development, and school readiness. They are performed in accordance with Washington State Department of Children, Youth, and Families (**DCYF**) ECEAP program standards, which require early identification of any health needs. We view this as a collaborative effort with you, the family, to ensure your child thrives.

DESCRIPTION OF SCREENINGS

The health screenings we will conduct (administered by the program's regional director or a trained staff member in a gentle, child-friendly manner) include:

- **Vision Screening:** We will use age-appropriate methods (such as an eye chart with symbols or pictures) to check your child's eyesight and detect any potential vision issues.
- **Hearing Screening:** We will perform a simple auditory test to ensure your child can hear sounds at typical levels, identifying any early signs of hearing difficulties.
- **Height and Weight Measurement:** We will measure and record your child's height and weight to monitor healthy growth and identify any potential concerns related to development or nutrition.

These screenings are non-invasive, will be conducted during program hours, and will be made as comfortable as possible for your child. If any screening indicates a possible concern, we will promptly discuss the results with you and, with your input, plan appropriate next steps (such as referrals for further evaluation). Our goal is to work together to support your child's well-being.

USE OF INFORMATION & PRIVACY (HIPAA)

We respect your family's privacy and are committed to protecting any personal health information collected. **All information and results from these screenings will be kept confidential** and used only for the purpose of supporting your child's health and development. Key points regarding information use and privacy include:

- **Limited Use:** Information from the screenings will be used solely to monitor your child's health status, to tailor our support in the classroom, and to make referrals for services if needed. This helps ensure your child has the best opportunity to learn and grow.



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- **Confidentiality & Security:** All screening results and records will be **kept confidential** and stored securely. We follow all applicable privacy laws and regulations, including the federal **Health Insurance Portability and Accountability Act (HIPAA)**. This means we have strict safeguards to protect your child's health information.
- **Controlled Sharing:** We will **not share your child's identifiable health information** with anyone outside of our program without your explicit written consent, except as required by law or ECEAP program oversight. Within the program, only authorized personnel (such as your child's teacher, the regional director, or a health coordinator) will access the information on a need-to-know basis. If a referral to an outside specialist or service is recommended, we will discuss it with you and obtain your consent before sharing any information.

By including this privacy assurance, we want you to feel confident that your child's information is handled with the utmost care and in compliance with HIPAA and state confidentiality policies. If you have questions about how we protect data, please ask.

VOLUNTARY NATURE OF PARTICIPATION

Participation in these health screenings is **completely voluntary**. You have the right to grant or refuse consent for your child's screenings:

- **Your Choice:** It is your decision whether or not to consent to these screenings. Choosing not to participate will not affect your child's enrollment or the services and care your family receives from our program. We respect your role as the primary decision-maker for your child.
- **No Penalty or Pressure:** There are no negative consequences if you decide to decline any or all of the screenings. We will continue to work with you to support your child in other ways. Likewise, you may consent to some screenings and not others, if that is your preference.
- **Withdrawal of Consent:** If you do provide consent, you retain the right to **withdraw your consent at any time**. Should you change your mind later, simply let us know in writing, and we will not proceed with any future screenings. (Please note that withdrawing consent will not undo any screenings that have already occurred, but those results will remain confidential.)
- **Family Empowerment:** We encourage you to ask questions and be involved in this process. Our commitment to equity and family partnership means we want you to feel **comfortable and empowered** in making decisions about your child's health. If you have any concerns or require accommodations (for example, being present during the screening, or needing interpretation in another language), we will do our best to honor your requests.

By emphasizing the voluntary nature of these screenings, we aim to **shift power dynamics** in our program: you, as the parent/guardian, are in control of what happens with your child. We are here to support and inform you, not to pressure you.



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CONSENT STATEMENT

Please indicate your decision below and sign to **give or decline consent** for the health screenings:

- **I give my consent** for YES for Early Success Cooperative (through its regional director or qualified staff) to conduct the vision, hearing, height, and weight health screenings described above for my child.
- **I do NOT give my consent** for the health screenings described above to be conducted on my child.

By signing this form, I acknowledge that I have read and understood the information provided to me in this consent form. I understand the purpose of the screenings, how the information will be used, and my rights regarding privacy and voluntary participation. I have had the opportunity to ask questions, and those questions have been answered to my satisfaction.

PARENT/GUARDIAN AND STAFF SIGNATURES

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ Date: _____

Staff (Regional Director) Name: _____

Staff (Regional Director) Signature: _____ Date: _____