

WEST VALLEY SCHOOL DISTRICT NO. 208

REPORT OF CHILD ABUSE AND/OR NEGLECT

A. PARENT(S) identification						CPS Report: Weekdays from 8 AM - 5 PM call: 1-509-225-6556 At all other times call: 1-800-562-5624 Fill out form as completely as possible. Give as much accurate information as you have. Do not guess or make assumptions. It will make your call easier to have this form completed <u>before</u> you call. Observing person must call CPS WITHIN 48 HOURS, then: - Inform Principal - Complete form, if not already done - Copy this report and mail to: Child Protective Services, PO Box 12500, Mail Stop, B39-12 Yakima, WA 98909 - Make sure this original is put into the Principal's/District Confidential File Date of Report : _____ Caseworker : _____									
MOTHER'S LAST NAME		FIRST		M.I.								BIRTHDATE			
FATHER'S LAST NAME		FIRST		M.I.								BIRTHDATE			
ADDRESS			CITY		ZIP							PHONE NO.			
CROSS REF/AKA/PREVIOUS NAMES															
C. NAMES OF CHILDREN (Circle children identified as victims)						E. TYPE CA/M (For CPS Use Only) (Check all that apply) <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Neglect Sexual <input type="checkbox"/> Abuse Medical <input type="checkbox"/> Neglect <input type="checkbox"/> Emotional Neglect/Abuse <input type="checkbox"/> Sexual Exploitation <input type="checkbox"/> Other _____									
LAST	FIRST	MI	BIRTHDATE	AGE	SEX							SCHOOL ATTENDED			
1.															
2.															
3.															
4.															
5.															
6.															
OTHERS IN HOUSEHOLD			RELATIONSHIP			(Check all that apply) <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Neglect Sexual <input type="checkbox"/> Abuse Medical <input type="checkbox"/> Neglect <input type="checkbox"/> Emotional Neglect/Abuse <input type="checkbox"/> Sexual Exploitation <input type="checkbox"/> Other _____									
HEALTH CARE PROVIDER			PRIMARY LANGUAGE									ETHNIC BACKGROUND			
OTHER SIGNIFICANT PERSONS			RELATIONSHIP												
E. REFERRANT IDENTIFICATION															
NAME OF REFERRANT			RELATIONSHIP			(Check all that apply) <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Neglect Sexual <input type="checkbox"/> Abuse Medical <input type="checkbox"/> Neglect <input type="checkbox"/> Emotional Neglect/Abuse <input type="checkbox"/> Sexual Exploitation <input type="checkbox"/> Other _____									
ADDRESS			TELEPHONE NUMBER												
REQUESTS CALL BACK ____ YES ____ NO		REQUESTS CONFIDENTIALITY ____ YES ____ NO													
G. SPECIFIC ALLEGATIONS: (Describe specific behaviors and conditions. Include where and when incident(s) occurred. If you have further background information which might place this child at risk for abuse/neglect, please indicate it. You may also use the back of this report.															
						(Check all that apply) <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Neglect Sexual <input type="checkbox"/> Abuse Medical <input type="checkbox"/> Neglect <input type="checkbox"/> Emotional Neglect/Abuse <input type="checkbox"/> Sexual Exploitation <input type="checkbox"/> Other _____									
H. Previous school district(s) and city (ies):															
I. ALLEGED PERPETRATOR IDENTIFICATION				J. RELATIONSHIP TO ALLEGED VICTIM				(Check all that apply) <input type="checkbox"/> PARENT ____ FOSTER PARENT ____ SCHOOL STAFF <input type="checkbox"/> PARENT'S PARAMOUR ____ DAY CARE ____ THIRD PARTY <input type="checkbox"/> RELATIVE ____ GROUP HOME ____ OTHER							
NAME															
ADDRESS		CITY		ZIP											
TELEPHONE NUMBER		ACCESS TO CHILD ____ YES ____ NO													
Building Principal's Signature:				Date:				Revised Date: 10/03							