Child's Name: _____

___ Confidentiality

___ Orientation & Receipt of Handbook

Nutrition: ___ Nutrition Enrollment (CACFP ONLY)

___ BMI Parent Notification

___ Growth Chart

Entry Date:_____

Licensing:

___ Admission Information (Form #2935 - **Licensed Campus)**

___ Physical Date: _____ 2nd Date: _____

___ HCG/Hbt Result _____

___ Lead Result _____

___ Blood Pressure Result _____

___ Dental Exam Date: _____ 2nd Date: _____

___ Immunization Record

___ Hearing & Vision Screening

___ Referral on Hearing/Vision (if needed)

___ Incident/Illness Report (Form #7239)

Enrollment:

___ Returning Student Update Form

___ Enrollment Form (Child Plus App)

___ Birth Certificate

___ Social Security Card

___ Driver's License

Income:

___ Selection Criteria

___ Eligibility Determination Record

___ Income Calculation Worksheet

___ Income Verification

___ Excessive Housing Calculator (if needed)

___ Excessive Housing Calculator Verification (if needed)

Consents:

___ Head Start Consents

___ Consent to Disclosure of Confidential Information

___ Consent to Release Record

Health:

___ Returning Student Health History

___ Health History & Nutrition Assessment

___ Insurance Card/Documentation of Health Insurance

___ Lead & TB Questionnaire

___ Mental Health - e-DECA

Health Request

___ Health Request and Correspondence (See Child Plus)
1st Request Date: _____
2nd Request Date: _____
3rd Request Date: _____
Refered to HS Date: _____

Action Plans:

___ Allergy

___ Ashtma

___ Diabetic

___ Seizure

Progress:

___ Behavioral Observation Statement

___ Transporation Safety Certificate

___ 1st Dial-4 (no screen on 2nd year student)

___ 2nd Dial-4 (if needed)

___ Circle Assessment 1st _____ 2nd_____3rd_____

___ Home Visit 1st _____ 2nd_____3rd_____

___ Parent/Teacher Conference 1st _____ 2nd_____3rd_____

Please place dates from Children's Activity List for Circle Assessment, Home Visits and Parent/ Teacher Conference.

Individualism: See Classroom

Head Start

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Orientation & Receipt of Handbook

Parent Orientation

I have participated in the Community Services of Northeast Texas, INC. Head Start Parent Orientation in which all of the program content areas were presented.

- □ Access to Minimum Standards and Performance Standards
- □ Child Abuse Orientation Sheet
- □ School Menus (available upon request)
- □ School Calendars located at www.csntexas.org
- □ Available for viewing on our website: Community Resource Directory, CACFP school menus, Volunteer Application, Immunization Chart, USDA Parent Letter, Building for the Future fyler, WIC information.

Receipt of Handbook

You are encouraged to read and understand this manual as there will be information that you may needduring the school year. The handbook includes:

Discipline and guidance	Procedures for release of children
Suspension and expulsion	Illness and exclusion criteria
Emergency plans	Procedures for dispensing medicines
Procedures for conducting health checks	Immunization requirements
Safe sleep	Meals and food service practices
Procedures for parents to discuss concerns with the director	Procedures to visit the center without securing prior approval
Procedures for parents to participate in operation activities.	Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website.
Class Schedules	Parent Rights

_____ I will access the parent handbook at www.csntexas.org.
_____ I would like a paper copy of the handbook.

Printed Name	Child's Name
Signature	Date
Employee Signature:	Revised: 1/22/2025

Head Start

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Returning Student Health History Update

Child's Name: _____

Child's Doctor: _____

Child's Dentist: _____

In case of illness or accident, do school officals and/or medical personal have your permission to necessary for the welfare of the above-named student (CPR, First Aid, Etc)? Yes _____ No _____

Health Questionnaire

1. Has your child suffered from any severe injuries, extended illness, or had surgery in the past year? □Yes □ No If Yes, Please Explain:
2. Does your child have any physical limitations: □Yes □ No If Yes, Please Explain:
3. Does your child have any of the following: □Seizures □ Asthma □ Food Allergies □Insect Allergies □ Environmental Allergies **(Action Plans may require updated forms. These will be sent to you by Family Serivce Worker)**
4. Is your child prescribed any of the following? □EpiPen □ Inhaler/nebulizer
5. List any daily medications to be given at school: Name of Medication: Time to be given: **(All medications MUST be accompanied with a Medication Administration log sign by the prescribing doctor. All medication must be in original pharmacy bottle.)**
6. Do you have any concerns about your child's development/speech or behavior? □Yes □No If Yes, Please explain:
Medical/Dental Insurance Medicaid Medical Medicaid Dental CHIP Medical CHIP Dental Private Medical Insurance Private Dental Insurance No Insurance

Consents, Authorizations and Releases

Completed at School: Vision/Hearing Screening, Height/Weight, Speech Screeing (Completed by teacher), Social- Emotional screener (completed by teacher & parent), Development Screening (Completed by teacher)

Other Permission: Consent for First Aid, Transportation (Field Trips/Emergency Care), Use of child's photograph (classroom, district website, campus newsletters, display boards), Audio/Visual Recording for edcuational purposes ONLY, sharing of records for purpose of ongoing program monitoring, transfer records to other Head Start center (if you move).

I **DO NOT** give permission for: _____

Printed Name	
Signature	Date
Employee Signature:	Revised: 1/27/2025

Community Services CSNT of Northeast Texas, Inc.

Head Start

"Building a better tomorrow"

Returning Student Update Form

Child's Name: _____

Current Address: Has address changed: □Yes □No

_____

Parent/Guardian Contact Number: Has contact number changed: □Yes □No

_____

My child may be released to the following people:

Name: _____ **Relationship:** _____

Phone Number: _____

Name: _____ **Relationship:** _____

Phone Number: _____

Name: _____ **Relationship:** _____

Phone Number: _____

I will access the handbook _____online at www.csntexas.org _____receive a paper copy

You can access the school calendar online at www.csntexas.org

Menus are available upon request

Parent Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Revised: 1/22/25

Head Start

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TB & Lead Questionnaire / Survey

TB Questionnaire

- Does your child have any of the following ***unexplained and untreated*** conditions? □ **Yes** □ **No**
  Cough for more than two weeks, loss of appetite, unexpected, rapid weight loss,
  chest pain, fever, chills or night sweats.
- Was your child born in or has your child lived in or visited a country where there is a lot of TB?
  (Mexico or Asia, Africa, Central or South America, Eastern Europe) □ **Yes** □ **No**
- Has your child been homeless or stayed in a shelter within the last 12 months? □ **Yes** □ **No**
- Has your child spent longer than 3 weeks with anyone who is/has been an IV drug user, HIV-infected,
  in jail or prison or recently came to the United States from a different county? □ **Yes** □ **No**

Has your child been tested for TB? □ **Yes** □ **No** If Yes, date of last testing: _____

Has your child ever had a positive TB skin test? □ **Yes** □ **No** If Yes, date of last testing: _____

Lead Questionnaire

- Does your child live in or visit a home, daycare or other building built build before 1978? □ **Yes** □ **No**
- Does you child live in or visit a home, daycare or other building with ongoing remodeling
  or reparis? □ **Yes** □ **No**
- Does your child eat or chew on non-food things like paint chips or dirt? □ **Yes** □ **No**
  Does your child have a family member who has or did have an elevated blood lead level? □ **Yes** □ **No**
- Is your child a newly arrived refugee or foreign adoptee? □ **Yes** □ **No**
- Has you child been exposed to contamination from parent, relative or friend with jobs like this?
  radiator repair, chemical preparation, pottery making, battery manfacture/repair, valve/pipe fitting
  lead smelting, welding, automotive repair shop, refinishing furniture, making fish weights, going to firing
  range □ **Yes** □ **No**
- Has you child be exposed to sources of lead in food/remedies?
  imported for glazed pottery such as Mexican bean pot, imported candy especially from Mexico,
  nutritional pills other than vitamins, food canned or packaged outside the US, remedies such as
  greta, azarcon, alarcon, alkohl, bali, goli, coral, ghasard, lig, pay-loo-ah, rueda □ **Yes** □ **No**

Printed Name	Child's Name
Signature	Date
Employee Signature: Revised: 1/22/2025	For office use _____ Refer for TB Testing _____ High Risk for Lead Lead Test Score: _____

Head Start

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HEAD START ENROLLMENT HEALTH HISTORY FORM

Child's Name: _____

Child's Doctor: _____

Child's Dentist: _____

Child's Insurance: **Medicaid** **CHIP** **None** **Private Insurance:** _____

Insurance Number: _____

Hospital in case of an Emergency: _____

Medication

Is your child currently taking any medication? □Yes □No

If yes, what medication and when does the child receive the medication? _____

_____

if your child receives medication at school, medication administration forms need to be completed by doctor

Medical

Is your child current with well-child exams? □Yes □No Date of Last Exam: _____

Is your child being treated by a physician for any of the following conditions?

- □ Anemia/Sickle Cell
- □ Asthma
- □ Diabetes
- □ Seizures
- □ Cardiac Disorders
- □ Vision Problems(glasses/difficulty seeing/headaches)
- □ Hearing Problems (difficulty hearing/tubes/earaches
- □ High Lead Levels

Please specify: _____

Does your child have any of the following allergies that require an EPI-PEN?

- □ Insect Stings/Bites
- □ Medication:_____
- □ Poison Ivy/Oak

If your child has an allergy, an ALLERGY ACTION PLAN will need to be completed by doctor

Does your child have any of the following problems?

- □ Seasonal Allergies: _____
- □ Eczema, hives, other skin problems
- □ Bed wetting
- □ Daytime wetting
- □ Frequent diarrhea
- □ Frequent urination
- □ Frequent constipation
- □ Painful urination
- □ Wears diapers/training pants
- □ Frequent indigestion
- □ Frequent stomachaches
- □ Frequent vomiting
- □ Other: _____

Does your child have any of the following conditions?

- □ Bites when angry/frustrated
- □ Bone/joint/muscle disease
- □ Fainting spells
- □ Bone/joint/muscle injury
- □ Hyperactivity
- □ Frequent fevers
- □ Trouble sleeping
- □ Lack of energy

Is your child seeing a medical specialist for ANY reason? □ Yes □ No

If yes, specify: _____

Is your child in pain right now because of their teeth? □ Yes □ No

Disability/Mental Health

Does your child have any of the following disabilities?

- ☐ Autism
- ☐ Emotional/Behavior
- ☐ Hearing Deafness
- ☐ Vision Blindness
- ☐ Learning Disability
- ☐ Orthopedic Impairment
- ☐ IDD
- ☐ Multiple Disabilities
- ☐ Speech/Language
- ☐ Traumatic Brain Injury

Is your child currently seeing a counselor or therapist? ☐ Yes ☐ No

If yes, who? _____

Did your child receive services from Early Childhood Intervention (ECI)? ☐ Yes ☐ No

**** speech/language, physical/occupational therapy***

Nutrition

Is your family currently involved with WIC?	☐ Yes ☐ No
Do you have concerns about your child's eating patterns? (picky eater, over/under eating, other)	☐ Yes ☐ No If yes, specify
Does your child take a vitamin or mineral supplement that contains iron and/or fluoride?	☐ Yes ☐ No If yes, specify
Were the supplements prescribed?	☐ Yes ☐ No
Are there foods not eaten for medical, religious, cultural, or personal reasons?	☐ Yes ☐ No If yes, specify
Is your child on a special diet?	☐ Yes ☐ No If yes, specify
Has your child's appetite changed in the past month?	☐ Yes ☐ No If yes, specify
Does your child have trouble chewing or swallowing?	☐ Yes ☐ No If yes, specify
Do you have any concerns about what your child eats or your child's weight?	☐ Yes ☐ No Please list concerns:_____ _____
Does your child have a food allergy documented by a physician?	☐ Yes ☐ No
Does your child need nutritional treatment?	☐ Yes ☐ No List the treatment you feel your child needs _____ _____
Is your child receiving nutritional treatment?	☐ Yes ☐ No List the treatment your child is receiving _____ _____

Printed Name	
Signature	Date
Employee Signature:	Date
Teacher's Signature:	Date

Revised: 1/27/2025

Head Start
"Building partnerships, changing lives"

EARLY HEAD START ENROLLMENT HEALTH HISTORY FORM

Child's Name: _____

Child's Doctor: _____

Child's Dentist: _____

Child's Insurance: **Medicaid** **CHIP** **None** **Private Insurance:** _____
Insurance Number: _____

Hospital in case of an Emergency: _____

Birth

Delivery Method: □Vaginal □C-Section
Birth Weight: _____ Length: _____
Gestation Age: _____weeks □Unknown
Birth Facility: _____

Describe any complications associated with this delivery (Pre-term labor, fetal distress, etc.)

_____

_____

Did the baby have any problems at birth? _____
Describe any observable defects._____
Did the mother have any health problems during this pregnancy (High Blood Pressure, Diabetes, etc.)

_____

_____

Medication

Is your child currently taking any medication? □Yes □No
If yes, what medication and when does the child receive the medication? _____

_____

if your child receives medication at school, medication administration forms need to be completed by doctor

Medical

Is your child current with well-child exams? □Yes □No Date of Last Exam: _____
Is your child being treated by a physician for any of the following conditions?

- □ Anemia/Sickle Cell
- □ Asthma
- □ Diabetes
- □ Seizures
- □ Cardiac Disorders
- □ Vision Problems(glasses/difficulty seeing/headaches)
- □ Hearing Problems (difficulty hearing/tubes/earaches
- □ High Lead Levels

Please specify: _____

_____

Does your child use diapers or pull ups? □ Diapers □ Pull Ups □ Potty Trained
Preferred Brand: _____
Size:_____

Does your child have any of the following allergies?

- ☐ Insect Stings/Bites
- ☐ Medication:_____
- ☐ Poison Ivy/Oak

Does your child require an EPI-PEN? ☐ Yes ☐ No

If your child has an allergy, an ALLERGY ACTION PLAN will need to be completed by doctor

Does your child have any of the following conditions?

- ☐ Bone/joint/muscle disease
- ☐ Fainting spells
- ☐ Bone/joint/muscle injury
- ☐ Hyperactivity
- ☐ Frequent fevers
- ☐ Trouble sleeping
- ☐ Lack of energy

Is your child seeing a medical specialist for ANY reason? ☐ Yes ☐ No

If yes, specify: _____

Dental

Is your child in pain right now because of their teeth? ☐ Yes ☐ No

Nutrition

Is your family currently involved with WIC?	☐ Yes ☐ No Where?
What does your child drink from?	☐ Regular Cup ☐ Sippy Cup ☐ Bottle
What milk does your child drink?	☐ Breast ☐ Whole Milk ☐ 2% ☐ 1% ☐ Lactose Free ☐ Other:
Is your child documented as lactose intolerant per physician?	☐ Yes ☐ No
Does your child take a vitamin or mineral supplement that contains iron and/or fluoride?	☐ Yes ☐ No If yes, specify
Were the supplements prescribed?	☐ Yes ☐ No
Are there foods not eaten for medical, religious, cultural, or personal reasons?	☐ Yes ☐ No If yes, specify
Is your child on a special diet?	☐ Yes ☐ No If yes, specify
Has your child's appetite changed in the past month?	☐ Yes ☐ No If yes, specify
Does your child have trouble chewing or swallowing?	☐ Yes ☐ No
Do you have any concerns about what your child eats or your child's weight?	☐ Yes ☐ No Please list concerns:_____
Does your child have a food allergy documented by a physician?	☐ Yes ☐ No If yes, specify
Does your child need nutritional treatment?	☐ Yes ☐ No List the treatment you feel your child needs _____
Is your child receiving nutritional treatment?	☐ Yes ☐ No List the treatment your child is receiving _____

Disability/Mental Health

Does your child have any of the following disabilities?

- ☐ Autism
- ☐ Emotional/Behavior
- ☐ Hearing Impairment
- ☐ Vision Impairment
- ☐ Learning Disability
- ☐ Orthopedic Impairment
- ☐ IDD
- ☐ Multiple Disabilities
- ☐ Speech/Language
- ☐ Traumatic Brain Injury

Did your child receive services from Early Childhood Intervention (ECI)? ☐ Yes ☐ No

**** speech/language, physical/occupational therapy***

If yes, which agency?_____ **IFSP in place?** ☐ Yes ☐ No

Does your child have any sleeping problems? ☐ Yes ☐ No
What time does your child go to bed? _____ Wake up?_____
Does your child take a nap? ☐ Yes ☐ No
Does your child sleep through the night? ☐ Yes ☐ No
Does your child have frequent nightmares? ☐ Yes ☐ No
Has your child been in daycare or go to a babysitter? ☐ Yes ☐ No
Does your child play well with others? ☐ Yes ☐ No

Special Concerns

List any additional concerns

_____

_____

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Staff Signature **Date**

I verify that I have reviewed this health history form and have taken any needed actions regarding this child.

_____ _____

Teacher Signature **Date**

Revised 3/3/25

Income Calculation Worksheet

For One Income

Child's Name:	Date of birth:

This wage-earner's name	Number of Adults	Children 6 to 18	Children under 6

Select all types of income:

- ☐ Employment Income
- ☐ Unemployment compensation
- ☐ Public Assistance (TANF, SSI,SNAP)

Verified Payment Frequency:

- ☐ **Weekly**
- ☐ **Semi-Monthly** (twice per month)
- ☐ **Bi-Weekly** (every two weeks)
- ☐ **Monthly**
- ☐ **Annual**
- ☐ **Other**

Enter >

HOW TO CALCULATE NORMAL MONTHLY INCOME

Use when "Other" is selected under EMPLOYMENT INCOME
or when check stubs do not represent normal hours worked.

Enter the normal hours worked weekly:

Enter the normal rate per hour:

This is the normal monthly amount: $ -

Enter this amount in the green box under EMPLOYMENT INCOME
AND CHECK THE MONTHLY FREQUENCY

Is this family homeless? ☐ Yes ☐ No

Is this child in foster care? ☐ Yes ☐ No

UNEMPLOYMENT COMPENSATION

Enter >

Income Totals:

% of FPV = **0.0%**

Employment

$ - Annualized: $ -

Unemployment Compensation

$ - Annualized: $ -

Total Annualized Income: $ -

DOCUMENTATION TYPE

Check each type of documentation used

- ☐ Income Tax Form 1040
- ☐ Living Arrangement Statement
- ☐ TANF / SSI / SNAP Documentation
- ☐ Pay Stub
- ☐ Unemployment Documentation
- ☐ Foster Care Documentation
- ☐ Excessive Housing Expense Form
- ☐ Written Statements From Employers
- ☐ Other _____
- ☐ Documentation of Income (attached)

Based on the information given, this child is:

ELIGIBLE - Income Calculation (100%)

The total annual pay calculated on this form is representative of my total annual income.
I understand, under penalty of perjury, that I have provided accurate and true documentation of my household income.

Parent/Guardian Signature	Date:

Comments/Remarks

For office use

Signature of Head Start employee _____ Date: _____

Income Calculation Worksheet

For Two Incomes

Child's Name:	Date of birth:
Child's Name:	Date of birth:

This wage-earner's name	Number of Adults	Children 6 to 18	Children under 6
Parent's Name:	1		1

Select all types of income:

- ☐ Employment Income
- ☐ Unemployment compensation
- ☐ Public Assistance (TANF, SSI, etc.)

HOW TO CALCULATE NORMAL MONTHLY INCOME

Use when "Other" is selected under EMPLOYMENT INCOME
or when check stubs do not represent normal hours worked.

Enter the normal hours worked weekly:

Enter the normal rate per hour:

This is the normal monthly amount: $ -

Enter this amount in the green box under EMPLOYMENT INCOME
AND CHECK THE MONTHLY FREQUENCY

Is this family homeless? ☐ Yes ☐ No

Is this child in foster care? ☐ Yes ☐ No

EMPLOYMENT INCOME

Verified Payment Frequency:

- ☐ **Weekly**
- ☐ **Semi-Monthly** (twice per month)
- ☐ **Bi-Weekly** (every two weeks)
- ☐ **Monthly**
- ☐ **Annual**
- ☐ **Other**

Enter >

UNEMPLOYMENT COMPENSATION

Enter >

Income Totals (FROM BOTH INCOMES):

% of FPV = **0.0%**

Employment
$ - Annualized: $ -

Unemployment Compensation
$ - Annualized: $ -

Total Annualized Income: $ -

DOCUMENTATION TYPE

- ☐ Income Tax Form 1040
- ☐ Living Arrangement Statement
- ☐ TANF / SSI / SNAP Documentation
- ☐ Pay Stub
- ☐ Unemployment Documentation
- ☐ Foster Care Documentation
- ☐ Excessive Housing Calculator
- ☐ Written Statements From Employers
- ☐ Other _____
- ☐ Documentation of Income (attached)

Based on the information given, this child is:

ELIGIBLE - Income Calculation (100%)

The total annual pay calculated on this form is representative of my total annual income.
I understand, under penalty of perjury, that I have provided accurate and true documentation of my household income.

Parent/Guardian Signature	Date:

Comments/Remarks

For office use

Signature of Head Start employee _____ Date: _____

Income Calculation Worksheet

Second Income

Child's Name:	Date of birth:
Child's Name:	Date of birth:

This wage-earner's name

Parent's Name:

Select all types of income:

- ☐ Employment Income
- ☐ Unemployment compensation
- ☐ Child Support
- ☐ Social Security Income (SSA, SSDA)

HOW TO CALCULATE NORMAL MONTHLY INCOME

Use when "Other" is selected under EMPLOYMENT INCOME
or when check stubs do not represent normal hours worked.

Enter the normal hours worked weekly:	
Enter the normal rate per hour:	
This is the normal monthly amount:	$ -

Enter this amount in the green box under EMPLOYMENT INCOME
AND CHECK THE MONTHLY FREQUENCY

EMPLOYMENT INCOME

Verified Payment Frequency:

- ☐ **Weekly**
- ☐ **Semi-Monthly** (twice per month)
- ☐ **Bi-Weekly** (every two weeks)
- ☐ **Monthly**
- ☐ **Annual** (tax form used)
- ☐ **Other**

Enter >

UNEMPLOYMENT COMPENSATION

Enter >

Employment
$ - Annualized: $ -

Unemployment Compensation
$ - Annualized: $ -

Total Annualized Income: $ -

- ☐ Income Tax Form 1040
- ☐ Living Arrangement Statement
- ☐ TANF / SSI / SNAP Documentation
- ☐ Pay Stub
- ☐ Unemployment Documentation
- ☐ Foster Care Documentation
- ☐ Excessive Housing Calculator
- ☐ Written Statements From Employers
- ☐ Other _____
- ☐ Documentation of Income (attached)

The total annual pay calculated on this form is representative of my total annual income.
I understand, under penalty of perjury, that I have provided accurate and true documentation of my household income.

Parent/Guardian Signature	Date:

Comments/Remarks

For office use

Signature of Head Start employee _____ Date: _____

TEXAS Health and Human Services

Form 2935
January 2025

Admission Information

Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

General Information

Operation's Name: Director's Name:

Child's Full Name:	Child's Date of Birth:	Child Lives With: ◯ Both parents ◯ Mom ◯ Dad ◯ Guardian	
Child's Home Address:	Date of Admission:	Date of Withdrawal:	
Name of Parent or Guardian 1:	Address of Parent or Guardian 1 if different from the child's:		
Name of Parent or Guardian 2:	Address of Parent or Guardian 2 if different from the child's:		
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Area Code and Phone No.:	Parent 2 Area Code and Phone No.:	Guardian's Area Code and Phone No.:	Custody Documents on File: ◯ Yes ◯ No
In case of an emergency, when the parent or guardian cannot be reached, call:			
Name of Emergency Contact:	Relationship:	Area Code and Phone No.:	
Address:			
I authorize the child care operation **to release** my child to leave the child care operation **only** with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.			
Name:	Area Code and Phone No.:		
Name:	Area Code and Phone No.:		
Name:	Area Code and Phone No.:		

Consent Information

1. Transportation:

I give consent for my child to be transported and supervised by the operation's employees. Check all that apply.

☑ for emergency care ☑ on field trips ☑ to and from home ☑ to and from school

2. Field Trips:

◯ I give consent for my child to participate in field trips. ◯ I do not give consent for my child to participate in field trips.

Comments:

3. Water Activities:

I give consent for my child to participate in the following water activities. Check all that apply.

☑ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds

Is your child able to swim without assistance?

◯ Yes ◯ No **Not Applicable**

If no, your child is required to wear a life jacket while in or near a swimming pool.

Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming?

◯ Yes ◯ No **Not Applicable**

If yes, your child is required to wear a life jacket while in or near a swimming pool.

Do you want your child to wear a life jacket while in or near a swimming pool?

◯ Yes ◯ No **Not Applicable**

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for the following. Check all that apply.

☐ Discipline and guidance
☐ Suspension and expulsion
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Safe sleep
☐ Procedures for parents to discuss concerns with the director
☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
☐ Procedures for parents to participate in operation activities
☐ Procedures for release of children
☐ Illness and exclusion criteria
☐ Procedures for dispensing medications
☐ Immunization requirements for children
☐ Meals and food service practices
☐ Procedures to visit the center without securing prior approval
☐ Procedures for supporting inclusive services
☐ Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline, and CCR website

5. Meals:

I understand that the following meals will be served to my child while in care. Check all that apply:

☐ None ☑ Breakfast ☐ Morning snack ☑ Lunch ☑ Afternoon snack ☐ Supper ☐ Evening snack

6. Days and Times in Care:

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday	7:30	3:00
Tuesday	7:30	3:00
Wednesday	7:30	3:00
Thursday	7:30	3:00
Friday	7:30	3:00
Saturday		
Sunday		

7. Receipt of Parent's Rights:

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

_____ _____

Signature — Parent or Legal Guardian **Date Signed**

8. Child's Special Care Needs, check all that apply

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations in the past 12 months
- ☐ Other: _____
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment, include instructions below
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use

Explain any needs selected above:

Does your child have diagnosed food allergies? ◯Yes ◯ No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit www.ada.gov/resources/child-care-centers/. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

_____ _____

Signature — Parent or Legal Guardian **Date Signed**

9. School Age Children

My child attends the following school: **NOT APPLICABLE**	School Area Code and Phone No.:

My child has permission to:
Check all that apply.

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of their sibling younger than 18 years old

Authorized pick up or drop off locations other than the child's address:

☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization For Emergency Medical Attention

In the event I cannot be reached to arrange for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician	Address	Area Code and Phone No.
Name of Emergency Care Facility	Address	Area Code and Phone No.

I give consent for the facility to secure any and all necessary emergency medical care for my child.

_____ _____

Signature — Parent or Legal Guardian **Date Signed**

Admission Requirement

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission. Select **only one** option.

- ◯ Health Care Professional's Statement: I have examined the above named child within the past year and find they are able to take part in the day care program.
- ◯ A signed and dated copy of a health care professional's statement is attached.
- ◯ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.
- ◯ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

Name of Health Care Professional, if selected

Address of Health Care Professional, if selected

Signature — Health Care Professional

Date Signed

Signature — Parent or Legal Guardian

Date Signed

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at https://hhs.texas.gov/policies-practices-privacy#security

Signatures

Child's Parent or Legal Guardian

Date Signed

Center Designee

Date Signed

Head Start

"Building partnerships, changing lives"

EHS Transition Plan

Child's Name: _____ Birthdate: _____
Initial Plan Date: _____ Date of Transition: _____
Transitioning to: _____

IFSP? □ **Yes** □ **No**	Current IFSP Date: _____ IEP Date: _____ School District Notified: □ **Yes** □ **No**	**Mental Health?** □ **Yes** □ **No**	Services Provided: □ **Yes** □ **No**

Family's Transition Plan:

- Discuss 3-year old transition
- Discuss Head Start Options, eligibility, and application process
- Share early childhood community offerings
- Share strategies for a successful preschool experience
- Offer classroom visit

Parent Comments

Teacher's Comments

Printed Name	Child's Name
Signature	Date
Employee Signature: Revised: 3/4/25	For office use _____ Referral to Incoming Head Start Progarm

Community Services Of Northeast Tex

Eligibility Configuration

Selection Criteria 2025-2026

Applies to:

Community Services Of Northeast Tex - Head Start 2025-2026

Automatically assign points based on Income

Foster	200
Homeless	200
Public Assistance	200
0 - 50%	85
51 - 75%	75
76 - 100%	65
101 - 130%	15
131 - 150%	10
151 - 400%	5

Automatically assign points based on Class Age

0 - 35 mo	0
36 - 41 mo	65
42 - 47 mo	75
48 - 53 mo	85
54 - 59 mo	95

Participant is not eligible if less than 36 months old on the school-year cut-off date or at the time of enrollment.

Participant is not eligible if 60 months old or older on the school-year cut-off date.

Other Eligibility Criteria

Attending and/or attended Early Head Start or ECI

95	Yes

Medicaid/CHIPS, CCMS, WIC

80	Yes

Parental Status

95	Guardian
90	One Parent/Dad
85	One Parent/Mom
80	Grandparent raising grandchild
75	Two Parent

Disability

100	Diagnosed Disabiity with IEP
85	Suspected Disability with explanation
0	No Diagnosed Disability

Child with sibling enrolled in the program

70	Yes

Open case with CPS

40	Yes

Over income with a Disability

100	Yes

4 Year old with a diability with an IEP

20	Yes

3 Year old with a disability with an IEP

25	Yes

Homeless, Foster, Kinship, TANF, SSI, SNAP

100	Yes

Community Services Of Northeast Tex

Eligibility Configuration

Selection Criteria 2025-2026

Other Eligibility Criteria		
ESL		
	100	Yes
Active Military		
	100	Yes
Former Foster Child		
	100	Yes
Three Year old in Pittsburg		
	40	Yes
Parent Currently Incarcerated		
	40	Yes
Parent works for ISD		
	40	Yes
Domestic Violence Victim		
	40	Yes
Parent works for HS/EHS		
	50	Yes

Community Services Of Northeast Tex

Eligibility Configuration

EHS Selection Criteria 2025-2026

Applies to:

Community Services Of Northeast Tex - Early Head Start 2025-2026

Automatically assign points based on Income

Foster	200
Homeless	200
Public Assistance	200
0 - 50%	85
51 - 75%	75
76 - 100%	65
101 - 130%	15
131 - 150%	10
151 - 400%	5

Automatically assign points based on Class Age

0 - 11 mo	75
12 - 23 mo	85
24 - 36 mo	95

Participant is not eligible if less than 12 months old on the school-year cut-off date or at the time of enrollment.

Participant is not eligible if 36 months old or older on the school-year cut-off date.

Other Eligibility Criteria

Medicaid/CHIPS, CCMS, WIC
- 80 Yes

Parental Status
- 95 Guardian
- 90 One Parent/Dad
- 85 One Parent/Mom
- 80 Grandparent raising grandchild
- 75 Two Parent

Disability
- 100 Diagnosed Disabiity with IEP/IFSP
- 85 Suspected Disability with explanation
- 0 No Diagnosed Disability

Child with sibling enrolled in the Head Start program
- 70 Yes

Open case with CPS
- 40 Yes

Income eligible, 130% or AG with disability
- 100 Yes

Homeless, Foster, SSI, TANF, SNAP
- 100 Yes

ESL
- 100 Yes

Active Military
- 100 Yes

Former Foster Child
- 100 Yes

Teen Parent
- 40 Yes

Community Services Of Northeast Tex

Eligibility Configuration

EHS Selection Criteria 2025-2026

Other Eligibility Criteria	
Parent Currently Incarcerated	
40	Yes
Domestic Violence Victim	
40	Yes
Parent works for ISD	
40	Yes
Parent works for HS/EHS	
50	yes