Region 7 ESC Head Start
1909 N Longview St. Kilgore, TX 75662 ● 903.988.6700

Date: _____________

SUSPECTED AND IDENTIFIED DISABILITY INFORMATION FORM

Head Start/ Early Head Start Disabilities Component

Child:	Site:
DOB:	Parent:

Question 1:

Ages birth to age 3: ***YES** ☐ **NO** ☐ Does your child **currently** receive ECI Service?
*if YES, complete consent on back of this form for Special Education records.

Ages 3-4: ***YES** ☐ **NO** ☐ Does your child receive Special Education services through the school?
(Ex. Speech/PPCD) *If YES, complete consent on back of this for Special Education records.

Question 2:

***YES** ☐ **NO** ☐ Does your child receive Private/Clinical Therapy?
*If YES, complete consent on back of this form to request clinical records.

☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy

Name of clinic/ therapy provider and/ or doctor: ______________________________

City: ____________________ State: ____________________

Ages 3-4:

***YES** ☐ **NO** ☐ Did your child **previously** receive ECI Services?
*if YES, complete consent on back of this form for ECI records.

Question 3:

***YES** ☐ **NO** ☐ Has your child been diagnosed with a medical condition affecting development?
*If YES, complete consent on back of this form.

Mark the DIAGNOSED condition below.

☐ ADD/ADHD ☐ Visual Impairment ☐ Hearing Impairment/ Deaf ☐ Down Syndrome
☐ Cerebral Palsy ☐ Seizure Disorder ☐ Speech Impairment ☐ Other: ____________

Physician name/ Clinic Name: ______________________________ City: ____________ State: ______

Question 4:

Does the Parent suspect a disability? **YES** ☐ **NO** ☐

Describe the Concern: ______________________________

If Speech, please explain: ______________________________

Question 5:

***YES** ☐ **NO** ☐ Have you contacted the district Special Education department about your child?
*If yes, complete consent on back of this form .

COMPLETE CONSENT ON BACK/ SECOND PAGE OF THIS FORM
WHEN COMPLETED, SCAN AND EMAILL THIS TO DISABILITIES: jcastaneda@esc7.net

"Region 7 Education Service Center is committed to district, charter, and student success by providing quality programs and services that meet or exceed our customers' expectations."

HEAD START & early head start
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1909 N Longview St. Kilgore, TX 75662 ● 903.988.6700

Date: ___________

____
Date of Expiration

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Student:	DOB:
Address:	School/ District:
City: State:	Zip:
Parent:	Parent Phone:

To the Parent: Head Start is asking that you authorize the person or agencies named below to disclose confidential information regarding the above named student.

Name/ Position:	&	**Attn:**
ISD/ SSA/ ECI:		Head Start Region 7 ESC
Address:		1909 North Longview St.
City: Zip:		Kilgore, Texas 75662
Fax:		Fax: (903)988-6945

RECORDS TO BE RELEASED/ DISCLOSED	PURPOSE OF RELEASE/ DISCLOSURE
☐ FIE/ Evaluations/ ARD/ IEP & Other Special Education Records	☐ To assist Head Start/ Early Head Start Staff in educational planning
☐ Receipts for Procedural Safeguards/ Guide to the ARD Process	☐ To assist Head Start/ Early Head Start Staff in documentation of records
☐ Notices & Consents for Evaluations	☐ To assist Head Start/ Early Head Start Staff in providing support
☐ ECI Records	☐ To assist in Head Start/ Early head Start transitions
☐ Other:	☐ To Allow Head Start/ Early Head Start Disabilities Staff to Attend ARDs

Parents: Please check the appropriate boxes below. For more information, contact the Head Start Disabilities Coordinator at (903)988-7665.

☐ YES ☐ No	I have been fully informed in my native language or other mode of communication and understand the request for my consent, as described above. This information will be disclosed upon receipt of my written consent.
☐ YES ☐ No	I understand that my consent is voluntary and may be revoked at any time. I understand that I cannot reverse any actions that occurred when consent was given and before revoked. My consent will expire one year from the date it was signed, unless previously revoked.
☐ YES ☐ No	I give my permission for the identified records to be released/disclosed to the Region 7 ESC Head Start Disability Staff.

Signature of Parent/ Guardian: ______________________________ **Date:** ____________

Signature of Interpreter, if used: ____________________________ **Date:** ____________

Please return this form to: Region 7 ESC Head Start Disabilities Staff noted above

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