Form: 6.01C

UPPER EAST TENNESSEE HUMAN DEVELOPMENT AGENCY, INC.
HEAD START PROGRAM

PARENT CONSENT TO RELEASE/OBTAIN INFORMATION

TO:_____ **FROM:**

_____

_____

Upper East Tennessee Human
Development Agency, Inc.
Head Start Program
P.O. Box 46, 301 Louis St.
Kingsport, TN 37662

Child:_____ **D.O.B.:**_____ **Date:**_____

I do hereby authorize:

UPPER EAST TENNESSEE HUMAN DEVELOPMENT AGENCY, INC. HEAD START PROGRAM

to release to or receive from:

_____

all records pertaining to:_____

for the purposes of:

1) determining if the child meets Head Start's disability guidelines and/or
2) determining if special services are necessary and/or
3) preparing an Individual Education Plan (IEP) and/or
4) preparing individual goals in the Head Start classroom.

Parent/Guardian:_____ _____
Signature Date

Original: Releasing/Receiving Agency
Yellow: Disabilities/Mental Health Coordinator
Pink: Child's Parent/Guardian

Upper East Tennessee Human Development Agency, Inc. Head Start Program

Referral Form

Please complete all blanks in the first section and only the remaining sections which are apply to the child being referred.

THIS REFERRAL MAY NOT BE NECESSARY IF YOUR FAMILY RESOURCE SPECIALIST IS ALREADY ADDRESSING THESE AREAS DUE TO A FAILED SCREENING.

Child's Name_____**D.O.B.**_____

Parents/Legal Guardian's Name_____ **Phone**_____

Address_____

_____

Center_____ **Teacher**_____

Are parents aware of the referral?_____

PHYSICAL/HEALTH REFERRAL

1. **Frequency of absences?** _____
2. **Does the child have allergies?**_____ **if so, what kind?**_____
3. **Is the child taking any kind of medication?**_____ **if so, what kind?**_____
4. **Does the child seem limited physically?**_____
5. **Date of last physical?**_____

Comments:_____

_____

VISION REFERRAL

1. **Does the child hold things close to or far away from face?**_____
2. **Does the child seem able to see only large, clear objects?**_____
3. **Is the child taking any kind of medication?**_____ **If so, what kind?**_____
4. **Does the child have difficulty distinguishing shapes and/or colors?**_____
5. **Date of vision screening?**_____ **Results: Pass**_____ **Fail**_____

Comments:_____

_____

HEARING REFERRAL

1. **Does the child have frequent colds and ear infections?**_____
2. **Does the child seem to turn his/her head to locate sounds?**_____
3. **Does the child understand better when looking at or sitting close to a person talking?**_____
4. **Does the child require repetition of directions?**_____

Comments_____

_____

TURN THIS FORM OVER FOR A DEVELOPMENTAL REFERRAL

DEVELOPMENTAL REFERRAL

THIS REFERRAL MAY NOT BE NECESSARY IF THE CHILD HAS A DIAGNOSED DISABILITY WITH AN ACTIVE IEP.

1. **Child's chronological age at the time of the last assessment?_____**
2. **Child's Brigance screening score?_____**
3. **LAP Scores in all areas:**

   _____

   _____

   _____

   _____
4. **Two or more areas in which the child has scored one year or more delayed:**

   _____

   _____

   _____
5. **Has there been any improvement over a 90 day time period?**

   _____

   _____

Comments _____

_____

_____

_____

_____

_____

Person Making the Referral_____

Date of the Referral_____

Person Receiving the Referral_____

Date Received_____

Form 6.06C

UETHDA, Inc. Head Start
DIAPERING FOR CHILDCARE

I, _____ understand that while my child is being cared for in the childcare room that he/she may need their diaper changed.

- ☐ I give permission for my child to have their diaper changed by the person's responsible for childcare while he/she is under their care.

- ☐ I do **NOT** give permission for my child to have their diaper changed by the person's responsible for childcare while he/she is under their care.

_____ _____
Signature Date

	DRY	**WET**	**BM**	**Comments:** (i.e. Diaper Change or Toilet)	**Initial**
Time:	_____	_____	_____		
Time:	_____	_____	_____		
Time:	_____	_____	_____		

UPPER EAST TENNESSEE HUMAN DEVELOPMENT AGENCY, INC.
HEAD START PROGRAM

Directions For Administering Head Start Speech Screening

Speech Screening Form: There is a Three and Four Year Old Speech Screening Form. The age of the child at the time you administer the speech screening will determine which form you will use. If the child is 3 years old when you administer the screening use the Three Year Old form. If the child is 4 years old at the time of screening use the Four Year Old form.

1. ***Articulation:***

   A. Show pictures (initials sounds). Listen for the (p) sound in "pig", (b) sound in "baby", etc. If the child does not recognize the picture, you may say "I call it a "pig" and then ask "What do I call it?"

   B. Show pictures (final sounds). This time you will be listening for the ending sounds.

2. Is the child's speech understandable? Can you understand most of what he/she says?

3. Does the child have a normal voice quality? Perhaps he/she sounds hoarse or like his/her nose is stuffy. If you indicate that his/her voice is not normal, please describe how it sounds.

4. Is the child fluent? Does he/she hesitate; repeat sounds or syllables; have trouble getting his/her words out? Most small children are sometimes disfluent. Please indicate only those who seem out of the ordinary.

Results: Circle (P) if the child has responded in an age appropriate manner.
Circle (F) if you are fairly sure that this child would require some intervention for speech and/or language.
Circle (R) if the child needs to be rescreened due to one of the reasons listed on the screening form. If none of those reasons fit, you must either circle pass or fail.

Helpful Hints:

*Check the age of the child and use the appropriate screening form. There is a different screening form for 3 year olds and 4 year olds.

*If a child (3, 4 and 5 year old) misses 2 or more sounds on either the initial or final categories, then they should be referred to the Disabilities/Mental Health Coordinator.

FOUR (4) YEAR OLD
UPPER EAST TENNESSEE HUMAN DEVELOPMENT AGENCY, INC.
HEAD START PROGRAM
Speech/Articulation Screening

Name:_____ D.O.B._____ Date: _____

Teacher: _____ Center: _____ Tester:_____

Home School System & School :_____

Date/Status of Vision:_____

Date/Status of Hearing:_____

(1) Please circle error sounds:

A: Initial Sounds b d h m n p f g k t w

B: Final Sounds m p b d g n k t f

(2) Is the child's speech understandable? Yes No

(3) Does the child have a normal vocal quality? Yes No

(4) Is the child's speech fluent? Yes No

Results: Pass[P] Fail[F] Rescreen[R] (check one)

_____ would not talk
_____ noncompliant
_____ crying

Comments:_____

_____

_____

_____

White Copy: Disabilities/Mental Health Coordinator (or Speech Pathologist if Failed)
Pink Copy: Teacher File
Yellow Copy: Disabilities/Mental Health Coordinator

THREE (3) YEAR OLD
UPPER EAST TENNESSEE HUMAN DEVELOPMENT AGENCY, INC.
HEAD START PROGRAM
Speech/Articulation Screening

Name:_____ D.O.B._____ Date: _____

Teacher: _____ Center: _____ Tester:_____

Home School System & School :_____

Date/Status of Vision:_____

Date/Status of Hearing:_____

(1) Please circle error sounds:

A: Initial Sounds b d h m n p

B: Final Sounds m p

(2) Is the child's speech understandable? Yes No

(3) Does the child have a normal vocal quality? Yes No

(4) Is the child's speech fluent? Yes No

Results: Pass[P] Fail[F] Rescreen[R] (check one)

_____ would not talk
_____ noncompliant
_____ crying

Comments:_____

_____

_____

_____

White Copy: Disabilities/Mental Health Coordinator (or Speech Pathologist if Failed)
Pink Copy: Teacher File
Yellow Copy: Disabilities/Mental Health Coordinator

Upper East Tennessee Human Development Agency, Inc.
Head Start Program

SPEECH THERAPY ATTENDANCE LOG

*CHILD'S NAME:*_____ *CENTER:*_____ *TEACHER:*_____

DATE	TYPE OF SERVICE (THERAPY, IEP MEETING, TESTING)	LENGTH OF TIME (30 MINS, 1HR, ETC)	CHILD ATTENDS THERAPY	CHILD ABSENT	NO BUS	THERAPIST CANCELLED	OTHER (SPECIFY)	INITIALS	COMMENTS

(Place 'X' in appropriate box)

Original - Disabilities/Mental Health Coordinator
Yellow - Teacher

Turn in monthly to Disabilities/Mental Health Coordinator