EDUCATIONAL RESOURCE
CENTER ON DEAFNESS

Dear Parent/Guardian:

Thank you for your interest in the *Parent Infant Program* at the Texas School for the Deaf. An application packet is enclosed. We will also need the following:

— Application Packet **completed**
— Record of Immunizations **most current**
— Copy of birth certificate or other form of legal identification
— Copy of social security card
— Custody papers (if applicable)

Please remember that we cannot start PIP services until Early Childhood Intervention (ECI) has set up an Individual Family Service Plan (IFSP). If you have not contacted ECI yet, please go to TexasDeafEd.org/0-3. On the right side of the page, click Early Childhood Intervention. You can search by city, county, or zip code.

If you need help with this process or have questions, please contact Rachel Baker, Lead PIP Teacher at:

- 512-462-5422 (voice)
- 512-626-5290(voice/text)
- 512-410-1638 (VP)
- rachel.baker@tsd.state.tx.us

EDUCATIONAL RESOURCE CENTER ON DEAFNESS

Referral to the Parent Infant Program at the Texas School for the Deaf

Getting Started

- You can apply to Early Childhood Intervention (ECI) or to the TSD Parent Infant Program for 0-3 services
  - To find your local ECI, go to TexasDeafEd.org/0-3 and click the link on the right for Early Childhood Intervention
  - TSD and ECI work together to service infants & toddlers who are deaf or hard-of-hearing (DHH) and their families

Paperwork Required by the State of Texas

- ECI and TSD need to get reports from the ENT doctor and the audiologist before services can start
- PIP staff can help ECI and your family with finding local ENT doctors
- It is important that families have an ENT for medical management (ear infections, hearing aids clearance, wax in ear canals, etc)
  - If your family is having trouble getting an appointment with the ENT doctor, please let us know so we can help you
- After ENT and audiologist reports are received by TSD, then ECI will schedule an evaluation. TSD will attend this meeting.
- TSD will send you a registration packet for the Parent Infant Program at the Texas School for the Deaf
  - **Please request a registration packet from Rachel.baker@tsd.state.tx.us or ercod@tsd.state.tx.us**
  - We cannot begin services with your family until your child is registered in school.
- After the evaluation, the DHH teacher will complete the Communication Evaluation and will share copies with both you and ECI

- **Services at TSD**
  - **Home services** are provided based on the needs of your family and child. These services are offered to all children ages birth through 35 months.
  - **School Services:** Children between 18 months and 35 months are also eligible to attend the Toddler Learning Center at TSD. Services are offered Monday through Friday from 8:00 – 11:30 during the regular school year.
    - Parents can choose both home and school services, or they can choose only one service if that best meets their needs
    - During the summer months, home services are offered to all families
  - The Toddler Learning Center is closed during the summer

Please contact us if you have any questions.

Parent Infant Program

Educational Resource Center on Deafness

Texas School for the Deaf

1102 S. Congress Ave.

Austin, TX 78704

512-462-5422 (voice)

512-626-5290 (voice/text)

512-410-1638 (VP)

email: rachel.baker@tsd.state.tx.us

ercod@tsd.state.tx.us

TEXAS SCHOOL FOR THE DEAF
ADMISSIONS
1102 South Congress Avenue
Austin, TX 78704
ADMISSIONS APPLICATION

Please Print or Type

Background Information:

Student/Adult Student's Full Name_____

Date of Birth_____Age_____

Home Address_____City_____State_____Zip_____

Place of Birth_____ Race _____SSN # _____

Home/VP # _____Cell/Text # _____E-mail _____

Does the student receive SSI, VA, SS or other income? Amount_____Name of Payee_____

Does the student have Medicaid? ☐ Yes ☐ No Medicaid #_____

Has this student (if over 16) ever applied for Department of Assistive and Rehabilitative Services (DARS)? ☐ Yes ☐ No

With whom does the student live?_____Relationship to student_____

Mother's Full Name_____Date of Birth_____

Home Address_____City_____State_____Zip_____

Home/VP # _____Cell/Text # _____E-mail _____

Place of Employment_____Work phone #_____

Position or Type of Work_____SSN #_____

Mother's Education-Years Completed: ☐ High School ☐ Some College ☐ College

What language should be used at meetings and/or for phone/videophone contacts?

☐ Spoken English ☐ ASL ☐ Spoken Spanish ☐ Other _____

Father's Full Name_____Date of Birth_____

Home Address_____City_____State_____Zip_____

Home/VP # _____Cell/Text # _____E-mail _____

Place of Employment_____Work phone #_____

Position or Type of Work_____SSN #_____

Father's Education-Years Completed: ☐ High School ☐ Some College ☐ College

What language should be used at meetings and/or for phone/videophone contacts?

☐ Spoken English ☐ ASL ☐ Spoken Spanish ☐ Other _____

Student Name: _____

Step-Parent/Guardian/Caseworker_____

Home Address_____City_____State_____Zip_____

Home/VP# _____Cell/Text # _____E-mail _____

Place of Employment_____Work phone #_____

Emergency Contacts for Student:

Name_____Relationship to student_____

Phone #_____ Type: ☐ Home ☐ Cell/Text ☐ VP

Name_____Relationship to student_____

Phone #_____ Type: ☐ Home ☐ Cell/Text ☐ VP

Name_____Relationship to student_____

Phone #_____ Type: ☐ Home ☐ Cell/Text ☐ VP

Is there anyone that is not allowed to have contact with the student? ☐ Yes ☐ No

Name_____

Who has legal custody? _____Relationship to Student _____

If there has been a divorce, please forward the most recent copy of the divorce decree to TSD so that custody and visitation rights can be identified. If you have custody paperwork, please forward a copy.

What is the best way to contact you?_____Best Time?_____

Family Members and Others Living in Home:

Name	Sex	Date of Birth	Deaf/Hearing?	Live In Home?

Student name: _____

Has this student ever lived outside the home?_____

_____

_____

Communication:

In which language would you prefer to receive written information from TSD? ☐ English ☐ Spanish

☐ Other_____

How does the student communicate with you? ☐ speech ☐ gestures ☐ signs

How do you communicate with the student? ☐ speech ☐ gestures ☐ signs

Does the student wear hearing aids? ☐ Yes ☐ No ☐ Sometimes

How much do you feel the student benefits from hearing aid(s)? ☐ Greatly ☐ Somewhat ☐ A Little ☐ None

Does the student have a cochlear implant? ☐ Yes ☐ No

If yes, when was it implanted?_____ Does the student still use it? ☐ Yes ☐ No

School History:

This section must be filled out completely.

Name of **Home School District**_____

Address_____City_____State_____Zip_____

Name of School District Student Attends (if other than Home)_____

Name of School Student Attends_____

Address_____City_____State_____Zip_____

Phone #_____Fax #_____

Student's Present Grade Placement_____

Check which best describes student's present educational placement: ☐ Mainstreamed ☐ Self-contained class

☐ Other: please describe_____

Student Name: _____

At what age did the student start school? _____

Has the student been suspended or expelled from any private or public school or institution? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

_____

Schools Previously Attended:

Grade	School/Address	Residential/Public	Dates

Has the student had a psychological or educational evaluation? ☐ Yes ☐ No

What were you told? _____

_____

_____

_____

Medical History:

Birth: Full-Term Pregnancy? ☐ Yes ☐ No If no, was the delivery: ☐ Premature? ☐ Delayed?

Please describe any complications_____

_____

_____

Student's birth weight_____Length_____

Cause of Deafness_____Age at Onset _____

Was the deafness onset: ☐ sudden? ☐ gradual? ☐ present at birth?

Student Name: _____

What is your understanding of the severity of the student's hearing impairment?

☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐ Other _____

Is the student taking any medications? ☐ Yes ☐ No If yes, please list:

Medicine _____ Dose _____ Reason _____

_____

_____

_____

Does the student have RX glasses or contacts? ☐ Yes ☐ No If yes, for what activities? _____

_____

_____

Does the student have any other physical problems? ☐ Yes ☐ No If yes, please explain _____

_____

Give approximate age at which the student did the following:

_____sat alone _____said/signed a single word

_____walked alone _____toilet trained

_____fed self

Please describe the student's general conduct and disposition (including any unusual behavior such as withdrawal, moodiness, hyperactivity, tantrums, etc.) _____

_____

_____

Is the student able to take care of his/her own personal needs? _____

_____

What concerns you most about the student's self help skills? _____

_____

_____ _____

Signature of Parent/Guardian/Adult Student Date

Texas Education Agency
Texas Public School Student/Staff Ethnicity and Race Data Questionnaire

The United States Department of Education (USDE) requires all state and local education institutions to collect data on ethnicity and race for students and staff. This information is used for state and federal accountability reporting as well as for reporting to the Office of Civil Rights (OCR) and the Equal Employment Opportunity Commission (EEOC).

School district staff and parents or guardians of students enrolling in school are requested to provide this information. If you decline to provide this information, please be aware that the USDE requires school districts to use observer identification as a last resort for collecting the data for federal reporting.

Please answer both parts of the following questions on the student's or staff member's ethnicity and race. ***United States Federal Register (71 FR 44866)***

Part 1. Ethnicity: Is the person Hispanic/Latino? ***(Choose only one)***

- ☐ **Hispanic/Latino** - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- ☐ **Not Hispanic/Latino**

Part 2. Race: What is the person's race? ***(Choose one or more)***

- ☐ **American Indian or Alaska Native** - A person having origins in any of the original peoples of North and South America (including Central America), and who maintains a tribal affiliation or community attachment.
- ☐ **Asian** - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **Black or African American** - A person having origins in any of the black racial groups of Africa.
- ☐ **Native Hawaiian or Other Pacific Islander** - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **White** - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Student/Staff Name (please print)	(Parent/Guardian)/(Staff) Signature
Student/Staff Identification Number	Date

TEXAS SCHOOL FOR THE DEAF
HOME LANGUAGE SURVEY

This form is to be completed for all students

STUDENT NAME:_____
Nombre del Estudiante LAST/Apellido FIRST/Nombre MIDDLE/Segundo Nombre

DATE OF BIRTH:_____
Fecha de nacimiento MONTH/Mes DAY/Día YEAR/Año

HOME LANGUAGE SURVEY (Información sobre el idioma que se habla en casa)

1. What language is spoken/used in your home most of the time?_____
   ¿Cuál es el idioma que más se habla/se usa en su hogar? Language/Idioma

2. What language does the student speak/use most of the time?_____
   ¿Cuál es el idioma que más habla/usa su niño(a) Language/Idioma

3. STUDENT'S COUNTRY OF BIRTH/País natal: _____

Signature of Parent/Guardian: _____ **DATE:**_____
FIRMA DEL PADRE/MADRE FECHA

Signature of Student (9th grade-ACCESS): _____ **DATE:**_____
FIRMA DEL PADRE/MADRE FECHA

*DATE SENT/MAILED:

Texas School for the Deaf
1102 South Congress Ave
Austin, TX 78704

☐ Release Information
☐ Request Information

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Student's Name: _____ D.O.B _____ Grade: _____

City : _____ State: TX _____ SSN : _____

To the parent/guardian/adult student: Texas School for the Deaf is obtaining your informed consent before the disclosure of confidential information of the student named above. IF you indicate YES in response to all the statements below and sign at the bottom, you are giving your consent for disclosure of confidential information.

, Admission Assistant
NAME AND POSITION OF SCHOOL STAFF PERSON

NAME OF PERSON/AGENCY TO WHOM THE REQUEST IS MADE:

ADDRESS: 1102 South Congress Ave
Austin, TX 78704

ADDRESS: _____

* STUDENT'S RECORD(S) TO BE DISCLOSED/RELEASED	*PURPOSE OF DISCLOSURE
☒ Review of Existing Evaluation Data (REED) or ☒ Full and Individual Evaluation and other evaluations or ☒ Psychoeducation evaluations ☒ All eligibility forms for the student named above ☒ Recent annual and other ARDs within the school year ☒ Notice and consent to test ☒ ARD or IEP meeting documents ☒ Transition Service Planning, if applicable ☒ Transcript, if applicable ☒ Report cards and progress reports, if applicable ☒ State test scores or achievement test scores ☒ Behavior reports (including BIP, MDR and FBAs) ☒ Medical information including immunizations and TB screening results ☐ Other:	To consider admission to TSD

Please check the appropriate boxes below. For more information please call:

_____ at: (512) 782-4262
SCHOOL STAFF PERSON — TELEPHONE NUMBER

☐ YES ☐ NO * I have been fully informed of the record(s) to be disclosed, the purpose of the disclosure, who will disclose the record(s), and who will receive the record(s).

☐ YES ☐ NO * I give my consent for the disclosure of confidential information.

☐ YES ☐ NO *I understand my consent for the disclosure of confidential information is voluntary and may be revoked at any time. However, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

☐ YES ☐ NO * The information provided to me has been provided in my native language or other mode of communication. If other than English, specify: _____.

*Your rights were explained to you when you were/your child was initially referred for special education assessment. Federal regulations require that parents and adult students be provided a full explanation of all procedural safeguards (rights) in their native language or other mode of communication each time the district proposes or refuses to initiate or change the identification, evaluation, or educational placement of you or your child or the provision of a free appropriate public education (FAPE) to you or your child. A copy of the procedural safeguards (rights) will be provided to you upon your request.

_____ _____
*SIGNATURE OF PARENT, GUARDIAN, SURROGATE PARENT, OR ADULT STUDENT — *DATE

(NEW) ADDRESS _____

_____ _____
*SIGNATURE OF INTERPRETER, IF USED — *DATE

Please return this form to: _____ at: _____
SCHOOL STAFF PERSON — ADMISSIONS/RECORDS

Required only when a school district does not include in its policy a notice that education records are forwarded to other agencies or institutions that have requested the records and in which the student seeks or intends to enroll.

HEALTH HISTORY: Please respond to each item. Please explain any "yes" answer in the space provided.

Dear Parent/Guardian,

The information you disclose on this form, and other registration forms, becomes a part of your child's cumulative school record, accessible to many school staff. Medical and Psychiatric information is communicated to specific residential, instructional, and other direct care staff if the information is determined to have impact on the student's education or the student's safety.

If there is health information that you wish to be confidential and accessed only by health care professionals, please disclose it directly to the Student Health Center or other TSD health care provider with written instructions regarding it's use.

UNLESS SPECIFIC PERMISSION IS GIVEN BELOW, only information about how a student's health condition or medications affect his/her functioning, behavior and safety in residential, recreational or instructional settings will be disclosed to non-health professionals by TSD health care providers.

Student's Name: _____ DOB: _____ Allergies: _____

Family Doctor: _____ Address: _____ Phone: _____ FAX: _____

Last Vision Exam: _____ Doctor: _____ Glasses? ☐ Yes ☐ No Contacts? ☐ Yes ☐ No

Last Dental Exam: _____ Dentist: _____ Braces? ☐ Yes ☐ No

Has this student ever experienced any of the following?	Comments - be specific & please note if medical care was received for the health complaint
Asthma ☐ Yes ☐ No	
Bedwetting ☐ Yes ☐ No	
Broken Bones / Dislocations ☐ Yes ☐ No	
Bruising Easily ☐ Yes ☐ No	
Chest Pain / shortness of breath ☐ Yes ☐ No	
Chewing / Swallowing Problems ☐ Yes ☐ No	
Depression ☐ Yes ☐ No	
Diabetes ☐ Yes ☐ No	
Dizziness / Fainting / Blackouts ☐ Yes ☐ No	
Ear infections ☐ Yes ☐ No	
Emotional Problems ☐ Yes ☐ No	
Eye Disease ☐ Yes ☐ No	
Frequent colds / sore throats ☐ Yes ☐ No	
Frequent Constipation ☐ Yes ☐ No	
Frequent Diarrhea ☐ Yes ☐ No	
Frequent Headaches ☐ Yes ☐ No	
Hay fever / Allergies ☐ Yes ☐ No	
Heart Problems / Murmur ☐ Yes ☐ No	
Heat Exhaustion/Heat Stroke ☐ Yes ☐ No	
Hemorrhoids ☐ Yes ☐ No	
Hyperactivity / Attention Deficit ☐ Yes ☐ No	
Joint Pain/ stiffness ☐ Yes ☐ No	
Kidney / Liver problems ☐ Yes ☐ No	
Nervousness ☐ Yes ☐ No	
Pain / Burning with Urination ☐ Yes ☐ No	
Pneumonia/Bronchitis/Persistent cough ☐ Yes ☐ No	
Pinched nerve/numbness/tingling ☐ Yes ☐ No	
Problems with teeth or gums ☐ Yes ☐ No	
Prolonged Bleeding ☐ Yes ☐ No	
Seasonal Allergies ☐ Yes ☐ No	
Seizures / Convulsions ☐ Yes ☐ No	
Skin Problems ☐ Yes ☐ No	
Stressed Out ☐ Yes ☐ No	
Sudden changes in appetite ☐ Yes ☐ No	
Unusual Gain / Loss Weight ☐ Yes ☐ No	
Vision problems ☐ Yes ☐ No	

Been knocked out ☐ Yes ☐ No

Become unconscious ☐ Yes ☐ No

Lost memory ☐ Yes ☐ No

If yes, how many times? When was the last concussion?

How severe was each one? How long were you restricted from activity?

Medical Devices

Cochlear Implant ☐ Yes ☐ No

Ear Tubes ☐ Yes ☐ No

Pacemaker ☐ Yes ☐ No

Protective/Corrective Equipment (ie. hearing aid, knee brace, etc) ☐ Yes ☐ No

Shunt ☐ Yes ☐ No

Trach ☐ Yes ☐ No

Tube Feeding ☐ Yes ☐ No

If this student is female, has she started her menstrual period? ☐ Yes ☐ No If yes, at what age did she start: _____

Does she take birth control pills? ☐ Yes ☐ No

Does she have any of these problems: Severe cramps? ☐ Yes ☐ No Irregularity? ☐ Yes ☐ No

Heavy Flow? ☐ Yes ☐ No Premenstrual syndrome? ☐ Yes ☐ No

Has this student had any of the following illnesses?

What age Complications?

Alcohol or drug use ☐ Yes ☐ No

Chicken Pox ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

Immune Disorder ☐ Yes ☐ No

Measles (Rubeola) ☐ Yes ☐ No

Meningitis or Encephalitis ☐ Yes ☐ No

Mumps ☐ Yes ☐ No

Rheumatic Fever ☐ Yes ☐ No

Rubella (German Measles) ☐ Yes ☐ No

Scarlet Fever ☐ Yes ☐ No

Strep Throat ☐ Yes ☐ No

Tuberculosis or exposure to it ☐ Yes ☐ No

Whooping Cough (Pertussis) ☐ Yes ☐ No

Have there been any syndrome or <u>other</u> illness/condition requiring medical care? ☐ Yes ☐ No

If yes, what? _____ **When did it occur?** _____

Please note doctors who have treated this student for <u>past</u> major illness, surgery or injury:

Doctor name: _____ Address: _____ Phone: _____

Doctor name: _____ Address: _____ Phone: _____

Is this student <u>now</u> under the care of physician(s) for any reason? ☐ Yes ☐ No (include family doctor)

If yes, for what reason? _____

Doctor name: _____ Address: _____ Phone: _____ FAX: _____

Doctor name: _____ Address: _____ Phone: _____ FAX: _____

Has this student ever been admitted to a hospital/psychiatric facility?

☐ Yes ☐ No If yes, date of admission: _____ Length of stay: _____

Reason for admission: _____

Name and address of facility: _____

Please complete entire form

Alcohol/Drug Use	Diabetes	High Blood Pres.	Sickle Cell Anemia
Arthritis	Emotional/Mental Condition		Stroke
Blood disorders Cerebral Palsy	Epilepsy/Seizures	Immune Disorder	Tuberculosis
Cancer (type)		Kidney Problems	
Deafness	Heart Disease	Other:	

Comments:

I signify my permission to fully disclose all health/medical information to the following designated groups of people. (Check all that apply) I understand that this permission can be revoked at any time. I also understand I can exempt specific facts from this release with written instructions to Student Health Services or another TSD health care provider.

☐ School Administrators ☐ Residential Administrators ☐ Teaching staff ☐ Residential Staff

PARENT/GUARDIAN SIGNATURE _____ RELATIONSHIP TO STUDENT _____ DATE _____

ADULT STUDENT SIGNATURE _____ DATE _____

Copy – Health Center

4/4/13

Please complete entire form

Name of Student: _____ DOB: _____ Parent/Guardian: _____

Parent/Guardian, when you child is a student at TSD:

- You are responsible for your child's medical expenses, which may be prescribed.
- You are responsible to provide medication for your child and to keep enough medication at home for weekends and school holidays, and to arrange for medications and medical information to be provided to the caregiver for your child for any unscheduled homegoings or non-TSD sponsored trips away from home and school. You will provide medications in original, labeled containers from the USA. Prescribing health care providers must be licensed in the USA.
- Your must send a copy of your child's insurance card or Medicaid card to TSD Health Center (if applicable). You will inform the Health Center of any change in the student's insurance status.
- You give permission for TSD health care providers to communicate with your child's physician in order to provide continuity of care and to assist the physician in monitoring the effects of prescribed treatments.
- According to state law, you are responsible to keep your child's immunizations current. If the child is not immunized in accordance with Texas Dept of State Health Services (DSHS) Guidelines, your child must return home. Parents must accompany minor children for immunizations.
- You must keep TSD Health Center informed of your current phone number, address, and emergency contacts.
- You are responsible for maintaining primary providers for medical, vision and dental needs and obtain routine annual examinations during homegoings, as well as arranging for continued medical care for any chronic conditions.
- You give permission for your child to be tested for HIV and Hepatitis in the event staff or another student is exposed to your child's blood or bodily fluids.
- You give TSD permission to consent to medical care from non-TSD health care providers if necessary for the health and well being of your child.
- You understand that TSD health care providers will communicate any health conditions and medical treatments to instructional and direct care staff on a need to know basis. Confidential information that does not impact behavior or education can be communicated privately with the nursing supervisor.
- You request the Health Center to administer medications and treatment as prescribed for your child.

TSD Provides the Following Services:

PHARMACY

TSD contracts with a pharmacy to provide 24-hour services for the students. In the event medication needs to be ordered for your child, the pharmacy is given medical, billing and insurance information to open an account. If the pharmacy does not accept the student's insurance, the medication will be ordered from the pharmacy of the parents' choice. **Except in emergencies, medications will not be ordered until parental consent is obtained.**

STUDENT MEDICATIONS – SEE PARENT/STUDENT HANDBOOK

If some of the student's medication must be transported home, a TSD staff person will sign it out from Health Center and allow parent/guardian to sign for it. If the student will travel unchaperoned, the TSD Health Center will inform you that the student will be carrying medication, and the medication will be packed into the student's suitcase.

The Health Center will schedule prescribed treatments and medication and monitor student compliance, unless expressly refused by you. High School and ACCESS students are expected to comply with prescribed medications/treatments with limited reminders, younger and Special Needs students will have closer supervision. The Health Center will pack needed medications for TSD sponsored activities and your child will be assisted to take the medication correctly by trained direct care staff. Medication that has been discontinued by your child's physician may be destroyed in a safe manner.

MEDICAL AND PSYCHIATRIC EMERGENCIES

In an emergency situation, the Health Center will assess the student's condition and provide basic emergency care. If necessary, the student will be referred to an emergency facility. **TSD will make every attempt to contact you as soon as possible.** Should a student require emergency medical or psychiatric treatment, TSD is authorized to communicate basic health information, such as immunizations, medical /psychiatric conditions, and prescribed medications to the emergency provider and to have their treatment records communicated to the Health Center.

HEALTH CARE AND SCREENING

When a student is ill/injured, he/she will be assessed and receive minor medical care and medication as indicated from the Health Center. In some situations, the student will be referred for follow up with the TSD physician. **Physician recommendations for medication will not be initiated until parental consent is obtained, unless a delay in treatment could harm the student.**

The Health Center will also perform state-required vision, acanthosis nigricans and scoliosis screening. Parents may choose to provide TSD with documentation that screenings have been completed. A copy must be sent to the Health Center for their records.

My signature below indicates I have read and understand my responsibilities and the health care role of TSD toward my child. I agree to all the above with the following exceptions:

_____

Signature Parent/ Guardian _____ Date _____ Signature of Student (18 or older) _____ Date _____

TEXAS SCHOOL FOR THE DEAF follows the immunization requirements specified by the Texas Department of Health. All immunization records must be validated by a physician. If a copy of the original Health Department immunization records is attached, the physician's signature is still required under PART I of this section. If history of illness is used in lieu of vaccine, additional verification is required.

PART I: Immunizations Received (Dates must include month and year)

VACCINE TYPE	DATE	DATE	DATE	DATE	DATE	DATE
DPT/Td/Tdap	1	2	3	B	B	B
HEPATITIS A						
HEPATITIS B						
HIB						
MCV 4						
MEASLES						
MUMPS						
PCV						
POLIO	1	2	3	B	B	
RUBELLA						
VARICELLA				Date of VARICELLA ILLNESS		
OTHER						
OTHER						
OTHER						
OTHER						
OTHER						

CURRENT TUBERCULOSIS SCREENING REQUIRED: **Result** of skin test/chest x-ray _____

(Within 12 month) Date given _____ Date read _____

****PHYSICIAN VALIDATION (Required):**
I, the undersigned physician, hereby certify this to be a true and accurate record of this student's immunization status.

_____
Physician's Signature

PART II: MEDICATIONS
If this student will be taking any medication while at school, we must have a written physician's order on file before we may administer the medication. Please provide this documentation in the space provided below. Unless otherwise prescribed, the stop date is the end of the current school year.

MEDICATION, DOSAGE, ROUTE AND FREQUENCY **STOP/DATE**

1._____ _____

2._____ _____

3._____ _____

I authorize the licensed nursing staff of Texas School for the Deaf to act as my agent to order the above medications from pharmacies.

_____
Physician's Signature Printed/Typed Name of Physician D.E.A. #

_____
Date of Examination Physician's Address & Telephone #

Copy – Health Center

TB Questionnaire

Dear Parent:

TB tests are not required for children under the age of 3. You do not need to take your child to the doctor for a formal TB test.

Please check the correct boxes in the chart (yes, no, don't know), and answer the two questions below the chart.

This will be all of the TB information we need for admission to the Parent Infant Program at TSD.

Thank you.

Name of Child_____Date of Birth _____

Organization administering questionnaire_____ Date_____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more that two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries?_____			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? Yes___ (if yes, specify date ____/____) No___

Has your child ever had a positive TB skin test? Yes___ (if yes, specify date ____/____) No___

For school/healthcare provider use only

****

PPD administered Yes___ No___

If yes,

Date administered _____/_____/_____ Date read _____/_____/_____ Result of PPD test _____ mm response

Type of service provider (i.e. school, Health Steps, other clinics) _____

PPD provider _____ _____

signature printed name

Provider phone number _____

City _____ County _____

If positive, referral to healthcare provider Yes___ No___

If yes, name of provider _____

TEXAS Department of State Health Services

Vision Screening Confidential Family Vision Questionnaire

Student _____

Name of person filling out this form: Relationship to student:		
If your child has worn glasses, how old was your child when he/she got glasses? _____ years old		
Does he/she have problems seeing objects far away, but sees up close? (nearsighted)	Yes	No
Does he/ he have problems seeing up close, but sees well far away? (farsighted)	Yes	No
Does your child ever complain of headaches while reading?	Yes	No
Does he/she ever complain of blurry vision?	Yes	No
Does he/she have difficulty seeing at night or in the dark?	Yes	No
Is he/ she afraid of the dark or of shadows?	Yes	No
Does he/she have difficulty seeing stars at night?	Yes	No
Does your child ever have difficulty finding small objects that have been dropped?	Yes	No
Does he/she ever ignore/fail to see others standing/signing by his/her side?	Yes	No
Does he/she have difficulty seeing sign language or gestures in dim light?	Yes	No
Does he/she "back up" to see others signing to him/her or to see pictures/photos?	Yes	No
Does he/she complain that bright lights hurt or bother him/her?	Yes	No
Does he/she need to wear sunglasses in order to see in bright sunlight?	Yes	No
Does he/she seem awkward/anxious when their eyes have to adjust to changes in light?	Yes	No
Does he/she ever confuse colors?	Yes	No
If yes, is the color problem with: ☐ red & green ☐ yellow & blue ☐ Dark colors: navy, black, or brown		
When was your child's last eye exam? _____ Doctor's name: _____		
At what age did he/she walk alone? _____ months		
Did your child crawl or move in an unusual way? (if yes, describe on back)	Yes	No
Does your child shuffle instead of picking up his/her feet when walking?	Yes	No
Does your child walk with his/her feet wider apart than most children?	Yes	No
Do you think he/she is clumsier than other kids the same age?	Yes	No
Does he/she often bump into objects and chairs?	Yes	No
Does he/she often knock things over at mealtime?	Yes	No
Does he/she stumble on stairs and curbs or have problems walking on bumpy ground?	Yes	No
Did the mother have problems during pregnancy or delivery? ☐ Yes ☐ No		
Newborn birth weight: _____		
Was your child born prematurely? (too early) ☐ Yes ☐ No If yes, how many weeks early? _____		
Did your baby have any problems like: ☐ Yellow jaundice ☐ Breathing problems ☐ Meningitis Other: _____		
How long did the baby stay in the hospital after birth? ____ days		
Was your baby on oxygen? ☐ Yes ☐ No If yes, how long? _____		

Please return to TSD Health Center

Updated 2/26/13

STUDENT INSURANCE INFORMATION

The Health Center staff at Texas School for the Deaf needs the following information filled out completely. Failure to do so will result in a possible delay of medical treatment.

STUDENTS INFORMATION

Name:	SSN:	Gender:
Doctor Name:	Grade:	DOB:
Doctor Phone:	Doctor Fax:	

PRIMARY INSURANCE INFORMATION (circle one) HMO PPO Other

Insurance Name:	Address:	
Phone:	Employer:	
Insured's Name:	Policy Holder:	
Policy #:	Group #:	Medicaid #:

SECONDARY INSURANCE INFORMATION (circle one) HMO PPO Other

Insurance Name:	Address:	
Phone:	Employer:	
Insured's Name:	Policy Holder:	
Policy #:	Group #:	Medicaid #:

☐ ***PLEASE CHECK IF YOUR SON/DAUGHTER DOES NOT HAVE INSURANCE.***

** **Note:** Please attach a copy of your child's insurance card

** **Note:** Please provide updated insurance changes if there are any changes.

** **Note: FOR RESIDENTIAL STUDENTS:** Your insurance may cover only emergency health care outside of your local area. Please inform your insurance company that your child stays in Austin Monday – Friday during the school term. Ask your insurance company how to obtain short-term specialist care in Austin if it is necessary. EXAMPLE: Orthopedic follow up after a broken bone. Please do not wait until there is an emergency.

Note: FOR RESIDENTIAL STUDENTS WITH MEDICAID: If you have the STAR or STAR+ program, you may want to change your Medicaid plan. Please ask the nurse about the other options that might access to health care in Austin easier.

Copy – Health Center - Athletics

SHARS

Dear Parent/Guardian:

In an effort to provide quality services, Texas School for the Deaf has been approved as a provider for School Health and Related Services (SHARS) for participation in the Texas Medicaid program. If you are currently covered under the Medicaid program, TSD will be able to obtain funding from Texas Medical Assistance Program (Medicaid) for providing your child with any of the following services as determined to be needed by the admission, review and dismissal (ARD) committee stated by your child's individual education plan (IEP).

Assessment	Audiology	Counseling
Medical diagnostic services	School health services	Occupational therapy
Physical therapy	Speech therapy	Psychological services

If you or your child are covered by other health insurance, the district needs to know. We cannot request Medicaid funds if any of these services are covered by other insurance. However, please be assured that the district will not take any action that will cost you anything.

As a parent, you have the right to choose a provider other than the school district; however, the provider you choose must be an approved SHARS provider. An approved provider may be the school, another agency, person, or organization chosen by the parent who is qualified to provide the services. Any approved provider chosen by the parent must agree to:

- Provide the specific services as listed in the IEP
- Provide the service or services in the least restrictive environment as written in the IEP and
- Maintain and submit all records and reports required by the school.

If you have any questions concerning this information please call the school district contact person listed below. Thank you.

School District Contact Person: Ms. Brenda Fraenkel
Telephone: (512)462-5412

_____ _____

Parent or Guardian's Signature Date

LIST BELOW PERSONS AUTHORIZED TO TAKE YOUR CHILD OFF CAMPUS: (These are limited to immediate family members, uncles, aunts, cousins, sisters, brothers, grandparents. Any others will need written permission from parent/guardian at the time of the request).

Overnight?

1. Name_____Relationship_____Yes___No____

Address_____Phone #_____

2. Name_____Relationship_____Yes___No____

Address_____Phone #_____

3. Name_____Relationship_____Yes___No____

Address_____Phone #_____

PLEASE keep us informed of any ADDRESS, PHONE and EMERGENCY CONTACT changes which may occur, ESPECIALLY UNLISTED TELEPHONE NUMBERS by calling the Records Office at 512/462-5412.

Is there anyone that is not allowed to contact your child? Yes_____No_____

If yes, TSD must have legal documentation on file.

Copy - Health Center

General Permissions Instructions

Dear Parent:

These permissions are used for all of the students at TSD. Clearly many of these do not apply to our children in the Parent Infant Program.

The permissions we do need to get from you are:

1. Media release
2. Use of Student work
3. Field trips
4. Wading activities at TSD

Please do check either "yes" or "no" for each of the different permissions on this form.

Thank you.

Student Name: _____

General Permissions

Please Check Yes or No For Each Activity to Indicate Permission or No Permission.

	Parent Permission		Type of Activity
1.	☐ Yes	☐ No	Media Release Permission I give my permission to the Texas School for the Deaf to photograph, audiotape, and/or videotape my child for news media coverage, electronic media (including TSD and/or ERCOD/ESC 11 Resource Websites), school brochures, publicity related to participation in co-curricular or extracurricular activities, or other events when the coverage will not cause excessive responsibilities and/or provides positive public relation opportunities.
2.	☐ Yes	☐ No	**Use of Student Work Permission** I give permission to the Texas School for the Deaf to display or publish my student's artwork or special projects on the school's website and/or in school publications. TSD agrees to use these student projects or artwork in this manner only.
3.	☐ Yes	☐ No	**Field Trips** I give my permission to the Texas School for the Deaf for my child to leave campus with teachers, cottage staff or other authorized personnel for school sponsored activities.
	☐ Yes	☐ No	**Residential Services/Student Life** I permit my child to participate in Residential Services or Student Life activities off campus. These activities could include going to parks or restaurants in and out of Austin, amusement parks outside of Austin, water parks in and out of Austin, and other various entertainment venues.
	☐ Yes	☐ No	**Religious Activities** I permit my child to participate in services and activities sponsored by the Jesus Lutheran Church, located across from TSD or the South Congress Church for the Deaf, located 2 blocks away.
	☐ Yes	☐ No	**Off Campus Privileges** I permit my High School child to "earn the privilege" of going off campus with at least one other High School student for up to five hours.
	☐ Yes		**Internet*** I give permission for my child to participate in TSD's Internet and electronic communication system and certify that the information contained on this form is correct. I understand that in order for my child to have use of e-mail I must grant permission for them to have access to the Internet. In consideration for the privilege of using the School's Internet and electronic communication system, and in consideration for having access to public networks, I hereby release the School, its operators, and any institutions with which they are affiliated from any and all claims and damages of any nature arising from my child's use of, or inability to use the system including policy and administrative regulations. ***Please see "Misuse of Computers and the Internet" In the Student Code of Conduct.***
		☐ No	***OR*** *I do not give Permission for my child to participate in the School's Internet and electronic communications system.*

_____ _____

Signature of Parent/Guardian **Date**

Student Name: _____

Swimming

Dear Parent: Before your child can join any swimming activity: 1) You must give permission; 2) the TSD Health Center must give permission; and 3) Your child's swimming abilities will be tested by a Lifeguard and your child's swimming level will be identified— either "deep-water swimmer", "shallow-water swimmer", or a "non-swimmer". All staff supervising any type of TSD swimming activity will know your child's swimming level.

Please Check Yes or No For Each Activity to Indicate Permission or No Permission.

4.

Parent Permission		Type of Activity
☐ Yes	☐ No	**Wading Activities at TSD and Other Swimming Areas** Students will occasionally be allowed to wade (walk in water 18 inches or less deep) on fieldtrips to creeks, ponds, springs and other locations that have shallow areas in which wading is permitted. Wading may also take place in rubber wading pools on or off the TSD campus.
☐ Yes	☐ No	**Instructional Swimming Activities at TSD** Instructional swimming activities take place in the TSD Swim Center. Instructional swimming is structured to teach the student how to swim or to perform water activities that a student must learn before the student learns to swim. A Lifeguard or Water Safety Instructor will teach the students and a Lifeguard will be assigned to guard during the activity.
☐ Yes	☐ No	**Recreational Swimming Activities at TSD or Off-Campus Pools** Recreational swimming activities take place in the TSD Swim Center and at pools off-campus. Students are allowed to go into the pool as deep as their swim level permits and swim or play. A Lifeguard(s) supervise recreational swimming.
☐ Yes	☐ No	**Recreational Activities in Natural Bodies of Water** TSD may conduct recreational activities at lakes, springs or other natural bodies of water. TSD will ensure that Lifeguards and other necessary supervision is provided for these activities.
☐ Yes	☐ No	**Recreational Activities Involving Motorless Watercraft** TSD may conduct recreational activities involving paddleboats, canoes, rowboats, small open craft, and small sailboats. For this type of activity, the student is supervised in a manner so that the student can safely enjoy the activity.
☐ Yes	☐ No	**Recreational Activities Involving Powercraft and Sailboats** TSD may conduct recreational activities that take place on large powerboats, sailing craft, barges and fishing boats. For this type of activity, the student is supervised in a manner so that the student can safely enjoy the activity.
☐ Yes	☐ No	**Recreational Skiing and Windsurfing** Selected students may be given the opportunity to participate in skiing and windsurfing activities. In-water supervision is provided for all of these activities.

_____ _____

Signature of Parent/Guardian **Date**

Cochlear Implant Information

Student's Name: _____ Grade: _____

Brand of cochlear implant: _____Cochlear _____Advanced Bionics _____Med El

Date/year of surgery: _____
Age of current processor: _____
Is the cochlear implant still under warranty for repairs? _____
If so, when does the warranty expire? _____

Name/Location of implant center: _____

Name of implant audiologist: _____

Phone number of center/audiologist (if known): _____

Date of most recent mapping: _____

How often does your child wear her or his cochlear implant?

_____ Daily
_____ Occasionally
_____ Mostly just at home
_____ Rarely
_____ Never

How much benefit from the cochlear implant does your child receive?

_____ Able to understand spoken language
_____ Able to understand some spoken language but still needs sign support
_____ Not able to understand spoken language but uses for awareness of speech/environmental sounds/music, etc
_____ Does not benefit

What kind of communication does your child use at home?

_____ ASL
_____ Other sign system (i.e. Signed English) _____
_____ Simultaneous communication (talking and signing)
_____ Spoken English
_____ Other spoken language (i.e. Spanish) _____

Does your child also use a hearing aid? _____

Will your child be enrolled in speech therapy at TSD? _____

How can we help support your child's cochlear implant use at TSD?

_____

1102 South Congress Ave
Austin, TX 78704

X Request Information

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Student's Name _____ D.O.B _____ Grade _____

City : _____ State: _____ SSN : _____

To the parent/guardian/adult student: Texas School for the Deaf is obtaining your informed consent before the disclosure of confidential information of the student named above. IF you indicate YES in response to all the statements below and sign at the bottom, you are giving your consent for disclosure of confidential information.

Audiology Dept.
NAME AND POSITION OF SCHOOL STAFF PERSON

NAME OF PERSON/AGENCY TO WHOM THE REQUEST IS MADE; PERSON/AGENCY MAKING REQUEST

ADDRESS 1102 South Congress
Austin, Texas 78704

ADDRESS: _____

* STUDENT'S RECORD(S) TO BE DISCLOSED/RELEASED	*PURPOSE OF DISCLOSURE
Audiological and cochlear implant information	Coordination of audiological services

Please check (✓) the appropriate boxes below. For more information please call:

_____ at: (512) _____
SCHOOL STAFF PERSON TELEPHONE NUMBER

☐ YES ☐ NO * I have been fully informed of the record(s) to be disclosed, the purpose of the disclosure, who will disclose the record(s), and who will receive the record(s).

☐ YES ☐ NO * I give my consent for the disclosure of confidential information.

☐ YES ☐ NO *I understand my consent for the disclosure of confidential information is voluntary and may be revoked at any time. However, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

☐ YES ☐ NO * The information provided to me has been provided in my native language or other mode of communication. If other than English, specify: _____.

*Your rights were explained to you when you were/your child was initially referred for special education assessment. Federal regulations require that parents and adult students be provided a full explanation of all procedural safeguards (rights) in their native language or other mode of communication each time the district proposes or refuses to initiate or change the identification, evaluation, or educational placement of you or your child or the provision of a free appropriate public education (FAPE) to you or your child. A copy of the procedural safeguards (rights) will be provided to you upon your request.

_____ _____
*SIGNATURE OF PARENT, GUARDIAN, SURROGATE PARENT, OR ADULT STUDENT *DATE

(NEW) ADDRESS _____

_____ _____
*SIGNATURE OF INTERPRETER, IF USED *DATE

Please return this form to: _____ at: _____
SCHOOL STAFF PERSON ADMISSIONS/RECORDS

Required only when a school district does not include in its policy a notice that education records are forwarded to other agencies or institutions that have requested the records and in which the student seeks or intends to enroll.
*Denotes required items

10/08

Copy – Audiology Dept

AND/OR IMPLANTED MEDICAL DEVICES

In the interest of students' safety, the TSD Medical Director and Student Health Services policy is:

For certain medical conditions, such as seizure disorders, visual impairments, cardiac conditions, orthopedic impairments or other potentially limiting conditions, each student should be assessed by the student's treating physician and any activity limitations specified in writing.

Con el mayor interés en la seguridad del estudiante, la póliza del Director Médico de TSD y de la Enfermería sigue:
A no ser que el médico privado del estudiante lo libre, el estudiante con implante coclear, shunt, marcador de pasos al corazón, u otros aparatos médicos implantados no se permite participar en deportes competitivos. Actividades físicas normales y clase de gimnasio se permiten y se animan. Si hay alguna pregunta sobre lo propio de alguna actividad, la situación debe revisarse por el médico privado antes de permitir la participación.

For recreational physical activities and P.E., physician clearance is required once on admission to TSD or once when a condition is newly diagnosed if the Student Health Services determines that a potentially limiting medical condition exists. It is part of the annual physical required for participation in competitive athletics. It may also be required again if the condition changes or the student plans to participate in new activities.

For cochlear implants, shunts, pacemakers, and other implanted medical devices no competitive sports are permitted unless previously cleared by the student's private physician. Normal physical activities and PE are allowed and encouraged. If there is a question about the appropriateness of any activity, the situation will need to be reviewed by the patient's private physician before it will be allowed.

Una vez el estudiante es inscrito en TSD, se requiere que el médico lo libre para actividad física y clase de gimnasio. Se requiere esta liberación anualmente para estudiantes que participan en deportes competitivos.)

_____ _____
STUDENT DOB

I UNDERSTAND THAT THE ABOVE NAMED STUDENT HAS:

___Cochlear implant ___Pacemaker ___ Shunt ___ Other(list)_____
___ Epilepsy ___ Usher's syndrome ___ other visual impairment (describe) _____
___ Cerebral Palsy ___ Long QT ___PE tubes or chronic TM perforation
___ Other medical condition(s): i.e. orthopedic, cardiac, respiratory or neurological (describe)_____
_____

If student is 15 or above and has seizure disorder or visual impairment: this student: ___ may ___ may not drive.
If student has seizure disorder, Musculoskeletal or neurological abnormalities, or TM perforation/tubes this student:
___may swim unsupervised ___may swim with a buddy ___may not swim ___may swim with earplugs

Please list other activity restrictions, PE and recreational activities, as well as competitive sports <u>THAT ARE NOT ALLOWED</u>.
PLEASE BE VERY SPECIFIC ABOUT ACTIVITIES THAT ARE RESTRICTED, ESPECIALLY RELATED TO CONTACT OR EXERTION THAT MIGHT BE CONTRAINDICATED.

<u>THIS STUDENT IS CLEARED FOR ALL ACTIVITIES EXCEPT:</u>

_____
_____

_____ _____
Physician's Signature Printed/Typed Physician's name

_____
Street Address, City, State & Zip

(____)_____ (____)_____ _____ _____ _____
Phone # Fax # DEA # (for controlled drugs RX) UPIN # (for lab orders) Date signed

SCHOOL YEAR AUGUST 20____ - JULY 20____

CHECK ALL THAT APPLY:

☐ A.M.

☐ MID (PIP only)

☐ P.M.

TEXAS SCHOOL FOR THE DEAF
DAY STUDENT
TRANSPORTATION REQUEST

School Year: 2017-2018

***ONE* Student Per Form**

TRANSPORTATION OFFICE USE ONLY
___ ADD
___ CHANGE
EFFECTIVE DATE:
____
Route #________
Route #________

Student: ____ **DOB:** __/__/__

Home Address: __________________________ **City** ________ **State** ____ **Zip:**________

Grade Level _____ **Program:** ☐ PIP ☐ ECE ☐ Elem. ☐ MS ☐ HS ☐ SND ☐ ACCESS

Parent / Guardian Name (s): ____

Preferred Contact Info:
Phone / Text: ________________________ **Email:** ______________________

Emergency Contact (name): __________________ **Phone / Text:** _______________

❖❖

Note: For the safety of the student, students will be picked up and delivered to the address(es) listed and released to the persons authorized to receive the student listed *ONLY*, unless other notice is received (& approved) in a timely manner. Multiple pickup/drop locations are NOT encouraged and must be reviewed and approved.

Pickup Address:__________________________________ **M T W TH F**
Name of Apartments:_____________________________ Circle all days needed

Delivery Address: __________________________________ **M T W TH F**
Name of Apartments:_____________________________ Circle all days needed

Please choose only *ONE* option below:

☐ **YES**, my child may be released at the delivery location ***without*** parent/adult supervision.
Parent Signature__________________________________ **Date:** ____/____/____

OR

☐ **NO**, my child is ***NOT*** to be released unsupervised. Persons authorized to receive student at the delivery location:

__________________________ __________________________

__________________________ __________________________

Special Aids:
☐ Wheelchair Lift ☐ Car Seat (child up to 36 inches) ____ Child's Current Height
☐ Other____________________________ NOTE-Booster chairs are *NOT* used on school buses)
Other pertinent Information (allergies, medical conditions, additional phone #'s, etc.)

____

____

❖❖

Special Note: Parents ***MUST*** notify the transportation office ***at least*** 30 minutes prior to pickup time if the student will not need the morning bus – call: 512-462-5391, text: 512-827-9399 or email: transportation@tsd.state.tx.us

Moving?: You must notify the Admissions Office of your new address and a new Transportation Request must be completed and signed by the parent before transportation can begin or resume. Allow 3 working days for transportation service to begin from date of receipt in Transportation Dept.

__________________________________ ____/____/____
Parent/Guardian Signature(s) Date