





# HOUSTON INDEPENDENT SCHOOL DISTRICT

## HEALTH INVENTORY

SCHOOL \_\_\_\_\_

DATE \_\_\_\_\_

HISD ID# \_\_\_\_\_

SCHOOL LAST ATTENDED \_\_\_\_\_

Please fill in this form and return to the teacher or nurse. The information given on this form will help the school staff to have a better understanding of your child's health needs:

Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Parent/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

### Have you ever been told by a doctor that your child had:

	Age First Identified	Under Doctor's Care?		Age First Identified	Under Doctor's Care?
Asthma			Bone/Joint Problem		
Allergies			Rheumatic Fever		
Blood Disorder			Surgery/Fractures		
Diabetes			T. B. Disease		
Epilepsy/Seizures			Hearing Loss		
Heart Disease			Vision Loss		
Kidney Disorder			Severe Menstrual Cramps		
Cancer			Eating Disorder		

### Please check if you have observed any of the following in your child:

\_\_\_\_\_ Tires easily      \_\_\_\_\_ Earaches      \_\_\_\_\_ Wheezing, shortness of breath with exercise  
\_\_\_\_\_ Frequent headaches      \_\_\_\_\_ Difficulty making friends      \_\_\_\_\_ Nail Biting  
\_\_\_\_\_ Fainting      \_\_\_\_\_ Coughs frequently at night      \_\_\_\_\_ Restlessness

Has your child been seen by a doctor for any of the above? ☐ Yes ☐ No

Is your child on any kind of medication? ☐ Yes ☐ No

If so, what? \_\_\_\_\_

For what condition? \_\_\_\_\_

Further comment \_\_\_\_\_

What type of medical insurance do you carry for this child?

CHIP ☐ Medicaid ☐ HCHD ☐ Private Insurance ☐ None ☐

Please see the School Nurse (or School Principal) if your child has other needs or is:

- A pregnant or parenting teen      Yes \_\_\_\_\_      No \_\_\_\_\_

**and/or**

- Has a severe life-threatening food allergy      Yes \_\_\_\_\_ Explain \_\_\_\_\_      No \_\_\_\_\_

Signature \_\_\_\_\_

# HOUSTON INDEPENDENT SCHOOL DISTRICT

## HOME LANGUAGE SURVEY

19 TAC Chapter 89, Subchapter BB, §89.1215  
(Home Language Survey applicable ONLY if administered  
for students enrolling in prekindergarten through grade 12)

### TO BE COMPLETED BY PARENT OR GUARDIAN FOR STUDENTS ENROLLING IN PREKINDERGARTEN THROUGH GRADE 8 (OR BY STUDENT IN GRADES 9-12):

The state of Texas requires that the following information be completed for each student who enrolls in a Texas public school for the first time. It is the responsibility of the parent or guardian, not the school, to provide the language information requested by the questions below.

Dear Parent or Guardian:

To determine if your child would benefit from Bilingual or English as a Second Language program services, please answer the two questions below.

If either of your responses indicates the use of a language other than English, then the school district must conduct an assessment to determine how well your child communicates in English. This assessment information will be used to determine if Bilingual or English as a Second Language program services are appropriate and to inform instructional and program placement recommendations. If you have questions about the purpose and use of the Home Language Survey, or you would like assistance in completing the form, please contact your school/district personnel.

For more information on the process that must be followed, please visit the following website:  
<https://projects.esc20.net/upload/page/0081/docs/JuneUpdates/EnglishLearnerIdentification-ReclassificationFlowchart.pdf>

**This survey shall be kept in each student's permanent record folder.**

NAME OF STUDENT: \_\_\_\_\_ STUDENT ID #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

CAMPUS: \_\_\_\_\_

**NOTE: PLEASE INDICATE ONLY ONE LANGUAGE PER RESPONSE.**

1. What language is spoken in the child's home **most of the time**? \_\_\_\_\_

2. What language does the child speak **most of the time**? \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Student if Grades 9-12

\_\_\_\_\_  
Date

**NOTE:** If you believe you made an error when completing this Home Language Survey, you may request a correction, in writing, only if:  
1) your child has not yet been assessed for English proficiency; and  
2) your written correction request is made within two calendar weeks of your child's enrollment 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.

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

# HOUSTON INDEPENDENT SCHOOL DISTRICT

## STUDENT ASSISTANCE QUESTIONNAIRE (SAQ)

All information MUST be completed by parent, school personnel or community liaison.

School \_\_\_\_\_ Date \_\_\_\_\_

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ HISD ID \_\_\_\_\_

Current Address \_\_\_\_\_ Grade \_\_\_\_\_ ☐ Male ☐ Female

Lives with: ☐ Both Parents, ☐ Mother, ☐ Father, ☐ Legal Guardian, ☐ Caretaker/Relative without legal guardianship, ☐ Other \_\_\_\_\_  
relation

Is the student currently in the conservatorship of the Department of Family & Protective Services (Foster Care)? ☐ Yes ☐ No

If Yes – name of DFPS Case Manager: \_\_\_\_\_ Contact information: \_\_\_\_\_

Was the student previously in the conservatorship of the Department of Family & Protective Services (Foster Care)? ☐ Yes ☐ No

**Please complete the Current Housing Situation AND Background Situation sections below to determine McKinney-Vento eligibility:**

### Part A: CURRENT HOUSING SITUATION – Check the student's current housing situation

#### I CURRENTLY LIVE:

☐ In my own home or apartment, in Section 8 housing, HUD Subsidized Housing or in military housing with parent(s), legal guardian(s), or caregiver(s) (if you checked this box, check one or both of the boxes below, if applicable).

☐ My home has no electricity ☐ My home has no running water

#### OR I CURRENTLY LIVE IN A TRANSITIONAL HOUSING SITUATION:

☐ Living in a shelter ☐ Living in a motel or hotel

☐ Living with more than one family in a house or apartment (Doubled-up) due to economic hardship

#### Unsheltered

☐ Moving from place to place ☐ Living in a structure not usually used for housing ☐ Living in a car, park, campsite, camper, or outside

**UNACCOMPANIED YOUTH -** ☐ Yes ☐ No (An unaccompanied youth is a student who is not in the physical custody of a parent or legal guardian. This would include students living with non-custodial relatives or friends without a parent or legal guardian.)

### Part B: BACKGROUND SITUATION (If a Transitional Housing Situation is checked above - please Check ANY below that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Catastrophic illness / medical expenses / disability | <input type="checkbox"/> Natural disaster / evacuation                            |
| <input type="checkbox"/> New to Town  | <input type="checkbox"/> Domestic Issue   |
| <input type="checkbox"/> Loss of Employment                                   | <input type="checkbox"/> Migrant work in fishing or agriculture                   |
| <input type="checkbox"/> Economic hardship/low earnings                       | <input type="checkbox"/> Awaiting placement in foster care / CPS custody          |
| <input type="checkbox"/> Evicted/kicked out                                   | <input type="checkbox"/> Parent(s) involved in military deployment                |
| <input type="checkbox"/> House fire or other destruction                      | <input type="checkbox"/> Parent Incarcerated/Recently released from incarceration |

### Part C: NEEDED SERVICES – based on availability (Check services needed and call 713-556-7237 to speak to an Outreach Worker)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Enrollment Assistance                          | <input type="checkbox"/> Transportation           | <input type="checkbox"/> Emergency Clothing, Uniforms  |
| <input type="checkbox"/> Free Lunch/Breakfast (Child Nutrition)         | <input type="checkbox"/> School Supplies          | <input type="checkbox"/> Personal Hygiene Items        |
| <input type="checkbox"/> Immunizations                                  | <input type="checkbox"/> Medicaid/CHIP Assistance | <input type="checkbox"/> Food Stamps (SNAP) Assistance |
| <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) | <input type="checkbox"/> Other _____              |  |

To the best of my knowledge this information is true and correct.

Name (PLEASE PRINT): \_\_\_\_\_ Signature \_\_\_\_\_ Phone #'s \_\_\_\_\_

**School Personnel:** This form is intended to address the McKinney-Vento Act U.S.C. 11435. If any "Transitional Housing Situation" is checked under "Current Housing Situation" AND the family has indicated one of the "Background Situations" (1) immediately add PEIMS Coding on the At-risk Chancery panel for At-risk reason code 12, (2) code all of the McKinney-Vento Panels on that screen (the start date should be the date the form was completed and also add the end date, and (3) Email forms to [HomelessEducation@houstonisd.org](mailto:HomelessEducation@houstonisd.org). If information is missing, please follow-up with the parent/guardian/school personnel who completed the form to make sure each section is completed, as needed.

# HOUSTON INDEPENDENT SCHOOL DISTRICT

## FAMILY SURVEY

STUDENT NAME:	DATE OF BIRTH:
CAMPUS NAME:	GRADE LEVEL:

Dear Parent/Guardian:

The Houston Independent School District is assisting the state of Texas to identify students who may qualify for the Migrant Education Program to receive additional services. **The information provided below will be kept confidential.**

Please answer the following questions and return this form to your child's school.

1. Have you or anyone in your household moved within the last 3 years from one school district to another in Texas or within the United States?









YES ☐ (Continue to question 2)

NO ☐ (Stop here and return survey to your child's school)

2. Were any of these moves made to find temporary/seasonal work in agriculture or fishing? (e.g., field work, canneries, dairy work, meat processing, etc.)

YES ☐ (Please check all that apply below)

NO ☐ (Stop here and return survey to your child's school)

 Fruit, vegetables, sunflower, cotton, wheat, grain, farms or ranches, fields & vineyards <input type="checkbox"/>	 Dairy farm <input type="checkbox"/>	 Fishery <input type="checkbox"/>	 Cannery <input type="checkbox"/>
 Poultry farm <input type="checkbox"/>	 Plant nursery, orchard, tree growing or harvesting <input type="checkbox"/>	 Slaughterhouse <input type="checkbox"/>	 Other similar work, please explain: <input type="checkbox"/>

If you answered "yes" to the questions above, an education representative will contact you to provide additional information. Please complete the following information:

Parent/Guardian Name	Home Address	Telephone Number

— FOR SCHOOL USE ONLY—  
PLEASE SUBMIT THIS INFORMATION AND FORMS AT

<https://form.jotform.com/200065674657156>

MIGRANT EDUCATION PROGRAM  
4400 W. 18<sup>th</sup> Street, Route 1 | Houston, TX 77092 | 713-556-7288  
HISD Multilingual Programs | 713-556-6980 Fax | January 2020

# HOUSTON INDEPENDENT SCHOOL DISTRICT

## STUDENT MEDIA CONSENT AND RELEASE FORM

This release allows the Houston Independent School District (HISD) to print, photograph, and record my child for use in efforts to promote HISD's activities and achievements. The consent includes allowing my child to be included and/or featured in materials to train teachers and/or increase public awareness of HISD schools through digital and print media including: newspaper, radio, TV, websites, blogs, and social media channels (Facebook, Twitter, YouTube, etc.), DVDs, displays, and brochures. This release includes the use of my child's work, name, image, and/or voice.

- ☐ I attest that I am the parent or guardian of \_\_\_\_\_ and **I GIVE** HISD and its employees and representatives permission to print, photograph, and record my child for use in electronic, digital, and printed media.
- ☐ I attest that I am the parent or guardian of \_\_\_\_\_ and **I DO NOT GIVE** HISD and its employees and representatives permission to print, photograph, and record my child for use in audio, video, film or any other electronic, digital, or printed media.

I agree to release the Houston Independent School District, its past, present and future trustees, officers, employees, representatives, and agents, from any and all liability, claims, demands, and causes of action arising out of the use of this material.

I certify that I have read this document and fully understand its terms and conditions. I also understand that I may withdraw consent at any time by sending a written request to the principal of my child's school.

### PLEASE PRINT

Name of child \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Name of parent or guardian \_\_\_\_\_

School \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_

Date \_\_\_\_\_ Phone Number \_\_\_\_\_

## Physician's Request for Special Dietary Accommodations

All sections must be completely filled out before form will be accepted.

Date: \_\_\_\_\_

**Part I (To be completed by Parent/Guardian)**

Name of Students (Last): \_\_\_\_\_ (First): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

School Attended: \_\_\_\_\_ Grade: \_\_\_\_\_ Student ID#: \_\_\_\_\_

Which meals will the child eat at school (please circle)?    **Breakfast**    **Lunch**    **After School Snack**

School Nurse/ Nurse Consultant: \_\_\_\_\_ Contact Information: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**I give Health Services/ Food Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Part II (To be completed by School Nurse or Physician)**

**Does the child have a disability?    Yes    No**

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, a "person with a disability" is any person who has a physical or mental impairment that substantially limits one or more life activities, has a record of such an impairment or is regarded as having such an impairment.

**If yes, please describe the major life activities affected by the disability:** \_\_\_\_\_

**Does the child have a life-threatening food allergy?    Yes    No**

If yes to any of the above questions, Part III must be completed and signed by a Licensed Physician.

If no to both questions, Part III may be completed and signed by a Licensed Physician or Recognized Medical Authority.

**Part III (To be completed by Licensed Physician or Recognized Medical Authority)**

**Medical Condition:** \_\_\_\_\_

**Foods to be omitted:**

\_\_\_\_ Fluid Milk    \_\_\_\_ All dairy products    \_\_\_\_ All milk protein (casein, whey, etc.)    \_\_\_\_ Soy protein  
\_\_\_\_ Wheat    \_\_\_\_ Gluten    \_\_\_\_ Eggs    \_\_\_\_ All egg protein (albumin, etc.)  
\_\_\_\_ Seafood    \_\_\_\_ Corn (as major ingredient)    \_\_\_\_ All corn additives (dextrin, caramel color, etc.)  
\_\_\_\_ Peanuts    \_\_\_\_ All Nuts    \_\_\_\_ All foods produced in a facility with nut containing products  
\_\_\_\_ Other (please be specific): \_\_\_\_\_

**Foods to be substituted:** \_\_\_\_\_

(For non-disabled students who cannot have fluid milk, food services will choose the most appropriate milk substitute.)

**Texture Modification:** \_\_\_\_ soft    \_\_\_\_ minced    \_\_\_\_ pureed    **other (specify)** \_\_\_\_\_

**HISD Formulary - Please choose from the following list:**

**Boost Kid Essentials 1.0    Nutren Jr.    Nutren Jr. with Fiber    Peptamen Jr. 1.5**

**Peptamen 1.5    Nutren 1.5**

\*Supplements not on the formulary list will take up to 6 weeks to be processed

**Supplement dosage per meal:**

\_\_\_\_ Breakfast    \_\_\_\_ Lunch    \_\_\_\_ After School Snack Program (if offered)

**Will the student eat a regular meal along with receiving a supplement?    Yes    No**

**Name of Medical Authority (please print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

*Send completed forms to school nurse/nurse consultant. **Physician requests must be renewed each school year.***

**Any change of treatment must be requested in writing by the physician.** To ensure that the request is processed prior to the first day of school, submit the request no later than one month prior to the first day of school.