Community Services CSNT of Northeast Texas, Inc.

Head Start

"Building partnerships, changing lives"

MENTAL HEALTH
CAMPUS INTERVENTION TEAM (CIT)
INFORMATION

Name of Student_____☐ M ☐ F Campus_____

DOB: _____ Teacher_____ Room Number_____

Parent's Name_____ Phone_____ Work Phone_____

Home Address_____ Cell Phone_____

Mailing Address_____

I. REVIEW STUDENT HISTORY

A. ☐Yes ☐ No Parent(s) are aware of your concern.
Date and method Parent's notified**:** _____

B. ☐ Yes ☐No Student previously received services ECI:
If yes when: _____

II. Specific learning or behavior concern:
_____

III. ☐ Yes ☐No Review screenings (Attach or List scores)
_____ Dial – 4
_____ ASQ-SE

_____ _____ _____
Signature of Parent/guardian Relationship Date

_____ _____ _____
Signature of Person Completing Form Position Date