COMMUNITY SERVICES OF NORTHEAST TEXAS

Head Start

INITIAL TREATMENT FORM

I hereby certify that I have treated my child, ___________________________________, for
student name

head lice on __________________with ______________________.
date of treatment *lice treatment used*

____
Parent signature *date*

****THE EMPTY CONTAINER OF LICE TREATMENT USED MUST ACCOMPANY THIS FORM FOR RE-ADMITTANCE TO SCHOOL.**

THE TREATMENT USED MUST BE A RECOGNIZED <u>MEDICAL</u> <u>METHOD</u> FOR TREATMENT OF HEADLICE.

Office use:
Date student excluded from school: ____________________

Examining person: ____

Date student re-admitted to classroom: __________________

Person verifying appropriate treatment and compliance: ___________________________________

Date student must be re-examined: Yes ____ *No* ____