



COMMUNITY SERVICES OF NORTHEAST TEXAS

Head Start

SECOND 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 MEDICAL METHOD 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* ____