LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Head Start/ECEAP Disabilities Staffing Form – Part 1

Child's Start Date: _____
Child's Full Name: _____ Birth Date: _____
Child's Ethnicity: _____ Birth Place: _____
Primary Language: _____
Parent(s): _____ Teacher: _____
Address: _____
Phone: _____ Head Start/ECEAP Location: _____
AM / PM / FD

Date of Referral to the School District: _____

Reason for Staffing child (Write in a brief summary/list area of concerns/check box if doctor referred child or if parent requested staffing or evaluation):

☐ Parent Request ☐ Doctor Referral

Information Attached:

Staff provides to Disability Specialist, at least 2 weeks before the staffing:

_____ Teacher Assessment Summary (DISA 2d)
_____ Vision and Hearing
_____ Sensory Profile (if applicable)
_____ TS Gold Documentation

Disability Specialist uploads to Google drive/shares with School District:

_____ ASQ 3 (all pages)
_____ ASQ SE-2 (all pages)
_____ DIAL-4: _____
_____ DIAL-4 Teacher Questionnaire
_____ DIAL-4 Parent Questionnaire
_____ Health History
_____ Parental Release of Information
_____ Other

Head Start/ECEAP Disabilities Staffing Form – Part 2

(to be completed at the staffing)

Decision:

☐ Monitor: For example, specialist observes, teacher collects data, child needs more exposure

- ☐ Specialist Observes (SLP, OT, PT, Special Education Teacher or School Psychologist)
- ☐ Teacher Collects the Following Data: _____
  _____
  _____
- ☐ Child Needs More Exposure
- ☐ Other: _____
  _____

☐ Re-Staff on: _____

☐ Evaluate in the following area(s):

- ☐ Adaptive/Self-Help
- ☐ Communication: _____
  (E=Expressive, R=Receptive, B=Both)
- ☐ Cognitive
- ☐ Fine Motor
- ☐ Gross Motor
- ☐ Social-Emotional
- ☐ Sensory

☐ No Action Needed

Comments: _____
_____
_____
_____
_____
_____
_____

Head Start/ECEAP Disabilities Staffing Form – Part 3

In-Person Attendance of Participants

Name	Signature	Title

DISA 2f

LOC ID# _____

LOWER COLUMBIA COLLEGE
Head Start/EHS/ECEAP

Date: _____ **Date of Birth:** _____

Child's Name: _____

Parent/Guardian Name: _____

Dear _____:
(School District)

Your patient is currently enrolled in the Lower Columbia College Head Start/EHS/ECEAP Program. At this time, program staff and I are requesting the following:

- ☐ Parent Consent for Evaluation
- ☐ Evaluation Summary (DOE)
- ☐ IEP Meeting Invitation
- ☐ IEP Records
- ☐ IEP At A Glance

Included with this letter is a completed Release of Information form signed and dated by the child's parent/guardian. Please send the requested information to my attention at:

LCC Head Start/EHS/ECEAP
P.O. Box 3010
Longview, WA. 98632

OR

Fax to (360) 442-2819
email: headstart.info@lowercolumbia.edu

Your time and assistance regarding this matter are greatly appreciated. I look forward to your reply.

Sincerely,

Sonja Sample
Disabilities Specialist

Fax Date & Staff Member Initials: _____

LOWER COLUMBIA COLLEGE
Head Start/EHS/ECEAP

LOC ID#_____

Date: _____ **Date of Birth:** _____

Child's Name: _____

Parent/Guardian Name: _____

Dear PROGRESS CENTER:
(Health Care Provider Name or Clinic Name)

Your patient is currently enrolled in the Lower Columbia College Head Start/EHS/ECEAP Program. As indicated, program staff and I are requesting the following:

- ☐ Parent Consent for Evaluation
- ☐ Evaluation Summary
- ☐ IFSP Meeting Invitation
- ☐ IFSP Records
- ☐ Treatment Notes
- ☐ Other _____

Included with this letter is a completed Release of Information form signed and dated by the child's parent/guardian. Please send the requested information to my attention at:

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