LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP

Head Start/ECEAP Disabilities Staffing Form – Part 1

Child's Full Name: ____
Child's Start Date: ______________________________ Birth Date: ___________
Child's Ethnicity:___________________________ Birth Place: _______________
Primary Language: ____
Parent(s): _______________________________ Teacher: __________________
Address: ____
Phone: ___________________ Head Start/ECEAP Location: __________________
AM / PM / SD

Dates of Staffing with School District: ____________________________________

Reason for Staffing child (Write in a brief summary/list area of concerns/check the boxes that are applicable.):

☐ Parent Request ☐ Doctor Referral ☐ Teacher Request

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 (Observations and/or Assessment Date Reports)

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
______ Behavior Incident Report (only if social/emotional referral)
______ 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: ____________________________

☐ Date of School District Referral to Evaluate: ____________________________

☐ Evaluate in the following area(s):

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

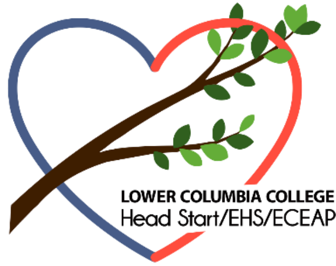
☐ No Action Needed

Comments: ____
____
____
____
____
____
____

Head Start/ECEAP Disabilities Staffing Form – Part 3

In-Person Attendance of Participants

Name	Signature	Title



DISA 2f

LOC ID# _______

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,

LCC Head Start/EHS/ECEAP
Education Staff

Fax Date & Staff Member Initials: ____________________

LOWER COLUMBIA COLLEGE
Head Start/EHS/ECEAP

DISA 2g

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:

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,

LCC Head Start/EHS/ECEAP
Education Staff

Fax Date & Staff Member Initials: ______________________

Lower Columbia College Head Start/ECEAP
Special Education Services Log

Child's Last Name	Child's First Name	Month	Year

Teacher's Name	Center	Loc ID #

Days of the Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Specialist/Service (ex: Jane Doe/SLP)	***Specialist*: Please write your initials on the day you provide service.**																														
Consultation																															
IEP Date:	IEP Service Time: **Weekly Direct and/or Group Instruction through Special Education Services and Classroom Instruction**																														

Legend: A = Child Absent NS = Therapist No Show S = Therapist Sick L = Therapist Arranged Leave T = Therapist Testing WD = Withdrawn

E = IEP Exit

Original: Area Manager for Review; Area Manager forward to Health Coordinator; Health Coordinator to Fiscal Specialist Copy: Child's Site File

Head Start/ECEAP Staff Signature   Date   Total Time

Legend: A = Child Absent   NS = Therapist No Show   S = Therapist Sick   L = Therapist Arranged Leave   T = Therapist Testing   WD = Withdrawn

E = IEP Exit

Original: Area Manager for Review; Area Manager forward to Health Coordinator; Health Coordinator to Fiscal Specialist   Copy: Child's Site File