

**Lower Columbia College Head Start/EHS/ECEAP  
Individuals Having Access to Records**

School Year \_\_\_\_\_

Site \_\_\_\_\_

Following is a current list of names and positions of officials who, because of their legitimate educational interest, may have access to personally identifiable information without consent from the parent or legal guardian. As required by the Head Start Performance Standard 1303.22 and FERPA.

*NOTE: The requirement to maintain a record of parties requesting or gaining access to student's records does not apply to the following persons:*

NAME	POSITION	NAME	POSITION
	Child Protective Services		Family Advocate
	School District Specialist(s)		Teacher
	Health Consultant		Area Manager
	Nutrition Consultant		Other LCC Head Start/EHS/ECEAP Leadership Team Member
	Mental Health Team		
	Self Assessment Team <i>(Head Start/EHS/ECEAP Staff Only)</i>		
	Federal and/or State Audit Team		
	Subpoena or Judicial Order		
	Progress Center		
	USDA		

Lower Columbia College Head Start/EHS/ECEAP  
Request for Change of Classroom

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Staff Name: \_\_\_\_\_

Current Teacher/Loc ID: \_\_\_\_\_ Requested Teacher/Loc ID: \_\_\_\_\_

Reason for request: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please provide any important information about the child and/or parent concerns:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Two Parent Family, both parents working/school
- Two Parent Family, one parent working/school

- One Parent Family, working/school
- One Parent Family, not working/school
- Kinship/Foster Family
- Attendance Issues

IEP: *School District* \_\_\_\_\_

IFSP: *School District* \_\_\_\_\_

Language:  English  Spanish  Other \_\_\_\_\_

Gender:  Male  Female

Toileting:  Diapers  Pull-ups  Underwear

Behavior Concerns:  Yes  No

Has the student been flagged by CAST?  Yes  No

Transportation: Is the student a bus rider?  Yes  No

Is the parent on the Policy Council?  Yes  No *(If so, forward to Administrative Supervisor)*

Will they need bus transportation to the new classroom?  Yes  No

*Once the form has been signed, please send to the ERSEA Supervisor.*

Teacher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Family Advocate/CFDS Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Area Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Approved:  Yes  No

ERSEA Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Lower Columbia College Head Start/EHS/ECEAP  
Request for Release to a Transitional Kindergarten Classroom**

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Staff Name: \_\_\_\_\_

Current Teacher/Loc ID: \_\_\_\_\_ Requested School District: \_\_\_\_\_

ROI Attached

Family reason for request: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

IEP: *School District* \_\_\_\_\_ IFSP: *School District* \_\_\_\_\_

Language: English \_\_\_\_\_ Spanish \_\_\_\_\_ Other \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ X (write in) \_\_\_\_\_

Toileting: Diapers \_\_\_\_\_ Pull-ups \_\_\_\_\_ Underwear \_\_\_\_\_

Developmental Needs: \_\_\_\_\_  
*(developmental and/or behavioral and assessment data)*

Transportation: Is the student a bus rider? Yes \_\_\_\_\_ No \_\_\_\_\_

Will they need bus transportation to the new classroom? Yes \_\_\_\_\_ No \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher/Family Advocate Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Area Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Once the form has been signed, please send to the ERSEA Supervisor.*

Is the parent on the Policy Council? Yes \_\_\_ No \_\_\_

Has the student been placed by CAST? Yes \_\_\_ No \_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

ERSEA Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date sent to school district: \_\_\_\_\_



Child's Name	Student's Primary Health Insurance Coverage (see attached choices)	Child has medical home? <b>OR</b> (see next question)	<b>OR</b> child received medical services through a federally qualified Health Center (FHC), Indian Health Services, Tribal and/or Urban Indian Health Program	Child has dental home? (Y/N)	Primary Parent Name	Primary Parent Employment Status (see attached choices)	Primary Parent Education Level (see attached choices)	Secondary Parent Name	Secondary Parent Employment Status (see attached choices)	Secondary Parent Education Level (see attached choices)	If child was in diapers, are they still? (Y/N)

**Student's Primary Health Insurance Coverage** (Please choose only one number.)

1. Apple Health State Issued (Medicaid) and/or CHIP
2. Private Health Insurance
3. Other Health Insurance: e.g., Military Health (Tri Care, CHAMPUS) etc.
4. No Health Insurance

**Primary and Secondary Family Member Employment** (Please choose only one number.)

1. Full Time and Training
2. Full Time (35 hours/week or more)
3. Part Time and Training
4. Part Time (Under 35 hours/week)
5. Retired or Disabled
6. Seasonally Employed
7. Training or School
8. Unemployed

**Primary and Secondary Family Member Education** (Please choose only one number.)

1. Associate's Degree
2. Bachelor's Degree
3. College Degree/Certificate
4. College or Advanced Training
5. General Education Diploma
6. Grade 10
7. Grade 11
8. Grade 12
9. Grade 9 or less
10. High School Graduate
11. Master's Degree

**LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP  
Preschool Area Manager Monthly Report**

AREA MANAGER \_\_\_\_\_ CENTER(S) \_\_\_\_\_ MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

**Attachments:**

- Classroom Tracking Summary Report; by center; last page only (cp.net E2501S)
- ELMS Family Support Visits and Parent/Teacher Conferences Report; by class

**Forward:**

- Original Special Education Services Logs (DISA 2j) to Disabilities Specialist
- Original Area Meeting Sign-In (HR 8j) and Agenda to Administrative Services Manager
- Reviewed and signed School Readiness at Home/Inkind (FISC 1e) to Fiscal Specialist
- Time and Effort to Fiscal Specialist

**Supervision/Monitoring completed (to date):**

LOC ID	File Review (# to date)	Creative Curriculum Fidelity Checklist (dates)	DST Checklist (date)		Lesson Plan Checklist (dates)	Classroom Observation Checklist (dates)	Active Supervision Checklist (dates)	TSG Analysis Quarterly (date to SRS)	TSG Percentages	
			Sept.	Jan.					Obs.	Prelim.

LOC ID	Case Management Observation (enter observation dates)				
	August	September (45 Day/HVs)	October (90 Day/PTC/FPA)	November	December

LOC ID	Case Management Observation (enter observation dates)					
	January	February (HVs/PTC)	March (PTC/HV/Tx Flup)	April	May	June

**Conferences (observations completed to date):**

Fall	Winter	Spring

**Home Visits (observations completed to date):**

School Readiness	Family Visit

**Cp.net report 3010 review:**

Classroom LOC ID	# of Medications in Classroom	Documented Health Accommodation Meeting for all ? (yes or no)	Classroom LOC ID	# of Medications in Classroom	Documented Health Accommodation Meeting for all ? (yes or no)

**# of Individual Care Plans:**

**Attendance Monitoring**

- # of children whose attendance is identified to be at risk of missing 10% (moderate): \_\_\_\_\_
- # of children whose attendance is identified at severe absence level (20% or more): \_\_\_\_\_
- # of families with an attendance SMART Goal: \_\_\_\_\_

**What are you doing as a center to address the attendance percentages?** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**# of referrals made to date (cp.net report 4120/ELMS):** Head Start: \_\_\_\_\_ ECEAP: \_\_\_\_\_

**# of Child Abuse/Neglect reports made this month:** \_\_\_\_\_

**# of Safety Intervention reports made this month:** \_\_\_\_\_

**Date Emergency Tests completed and documented on DCYF Emergency Drill Record for the center:**

**Professional Development Plans (to date):**

Fall	Winter	Spring

**Performance Evaluations – include probationary (to date):**

Number completed this month:	
Total number completed to date:	

**Staff Qualifications Spreadsheet is up-to-date:** yes \_\_\_\_\_ no \_\_\_\_\_

**Original Updated PDP sent to Administrative Services Manager:** yes \_\_\_\_\_ no \_\_\_\_\_

**Community Involvement:** List community meetings, boards, committees attended where you represented Head Start/ECEAP. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Things that went well this month:**

For You: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For Your Site(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**My ideas, goals and plans for next month:**

For You: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For Your Site(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I have attended and/or would like:**

For you: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For Your Staff: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Monthly Report Due to Operations Manager by the 10<sup>th</sup> of the month.***

