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:
  Expressive ◯ Receptive ◯ 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