DISA 2g

LOC ID#_____

LOWER COLUMBIA COLLEGE
Head Start/EHS/ECEAP

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

Child's Name: _____

Parent/Guardian Name: _____

Dear PROGRESS CENTER:

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: _____

(C: 01/07; R: 07/25)

Checked for Accessibility: GM, ECR, 06/12/2026, Adobe Acrobat Accessibility Checker