



Student Support Information Checklist - Applicant

Student Name: _____ Date: _____

D.O.B.: _____ Grade: _____ Current School: _____

Date of most recent testing: _____ Re-evaluation date: _____

Diagnosis 1: _____ Diagnosis 2: _____ Diagnosis 3: _____

<i>Task</i>	<i>Initial/Date</i>	<i>Comments</i>
Student Supplemental Information Form		
Full Psych Ed		
Speech/Language Report		
OT Report		
PT Report		
ABA/Behavioral Specialist		
Professional Communication #1:		
Professional Communication #2:		
Professional Communication #3:		
IEP		
Teacher Recommendation		
Schedule Visit		
Medical Professional		
Student Support Plan (if Catholic School Transfer)		



Student Supplemental Information

(To Be Completed by Parents)

Student Name _____ DOB _____

Family History

Please share information about the support/ intervention your child has received, if any. **If evaluations have been completed, please provide a copy of the report.**

At what age did you suspect your child may need intervention? _____

What indicators did you see? _____

Is there a family history of learning differences? If yes, please explain.

Is your child adopted? _____ If yes, does he/she know? _____

Have there been any important events (e.g. moving, divorce, accidents, illness, deaths) in your family that have affected your child? If yes, how do they affect your child now?

Medical History

What operations, accidents, illnesses and/or hospitalizations has your child had and at what age? Please describe the circumstances.

Does your child have any chronic conditions (e.g. allergies, asthma, epilepsy)? _____

Is your child on medication currently? _____ If yes, what medication and what is the reason for use? _____

Does your child have a history of high fevers and/or seizures? If so, please describe: _____

Does your child have a history of ear and/or respiratory infections? If yes, please describe.

Physical Development

At what age did your child do the following:

Walk? _____ Talk? _____ Stand? _____ Tie shoes? _____ Ride a bike? _____ Toilet Trained? _____

What are your child's sleeping habits? What difficulties do you encounter, if any?

What are your child's present eating habits? What difficulties do you encounter, if any?

What was your child like as a toddler? For instance, was he/she quiet, easy-going, clingy, independent, impulsive, enthusiastic, defiant, negative?

What was your child's reaction to his/her first school and/or daycare experience? Did he/she have a hard time separating at the beginning?

Language Development

At what age did your child say his/her first words? _____

At what age did your child begin combining 2 and 3 words together? _____

Does your child have difficulty organizing and expressing his/her ideas? _____

Can he/she retell a story in logical order? _____

Other than English, are there other languages spoken at home? If so, which language/s and by whom? _____

Social Development

What is your child like at home? Please include your child's activity level and relationship with siblings.

Are your child's friends the same age, older or younger? _____

How does he/she generally get along with friends?

What are your child's interests, skills, hobbies?

What sports does your child play, if any?

Describe any counseling your child has received or is receiving:

Academic Development

Academic strengths of your child:

Academic needs of your child, such as difficulties reading, math, and/or language:

Study and work habits of your child:

Describe how your child manages obstacles/challenges. Does he/she persevere? Give up easily?

Describe the organizational skills of your child:

Please briefly describe any particular circumstances which may have affected your child's record in school, including but not limited to: attention or behavior difficulties, medical needs, hospitalizations and frequent changes of school. Please include dates when possible.

In what ways would you most like to see your child develop during his/her year in the Diocese of Nashville Catholic Schools?

Professional Reference Release of Information

Parent/Guardian: Please complete this form by listing professional providers and their contact information below. Professional providers can include a classroom teacher from another school, educational tutor, speech language pathologist, psychologist, counselor, etc. Please indicate the services provided by each reference listed.

Student Name: _____ **Date of Birth:** _____

Professional Provider:

Name: _____ **Position:** _____

Phone: _____ **Fax:** _____

Email: _____

Professional Provider:

Name: _____ **Position:** _____

Phone: _____ **Fax:** _____

Email: _____

Professional Provider:

Name: _____ **Position:** _____

Phone: _____ **Fax:** _____

Email: _____

Your signature gives (school name) _____

Staff permission to contact via phone, email, fax and/or written request for release of transcripts, teacher reports, evaluations, standardized testing, and all other information pertaining to the educational, physical and emotional status of my child.

Signature

Date

Signature

Date



Student Support Plan: General

School Year: _____

Student Name: _____ D.O.B.: _____

School: _____ Grade: _____ Meeting Date: _____

Primary Diagnosis: _____ Secondary Diagnosis: _____

Evaluation Date: _____ Evaluator: _____

Date of Re-evaluation: _____ Support Team Manager: _____

Speech/Language Evaluation Y/N If yes, Therapist: _____

OT Evaluation Y/N If yes, Therapist: _____

Additional Information (title services/tutoring/counseling/etc.): _____

Student strengths/ways to implement during the school year:



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Speech/Language Evaluation Y/N If yes, Therapist: _____

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Additional Information (title services/tutoring/counseling/etc.): _____

Student strengths/ways to implement during the school year:



Student Support Plan: Student Goal/s and Progress

Please add additional goals as needed. Complete both pages of this document for each goal.

Student Name:
Content Area:
Person(s) responsible for implementing goals on this page:
Annual Goal:
Methods/Materials:
Parent Contributions:

Short Term Objectives/Benchmarks	Start Date	Criteria for Mastery	Methods of Evaluation	End Date



Student Support Plan: Student Goals and Progress, Cont.

Student Progress and Recommendations:

November:

February:

May:

For Catholic Schools supports only and may not allow services beyond the Catholic school environment.



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Accommodations

Student:
School Year:
Date:

Check all that apply.

ACADEMICS:	ORGANIZATION:
Extra time to complete assignments	Peer help with organizational skills
Directions given orally/in writing	Sending home daily/weekly progress notes
Provide multi-sensory hands-on Instructional activities	Teacher and parent initial homework/ assignments
Shorten length of assignments	Provide homework assignment notebook
Divide assignments into steps	RESPONSE TO BEHAVIOR:
Use concrete manipulatives	Praising specific behaviors
Use visual aides	Cueing student to stay on task
Use highlighted texts	Classroom behavior management system
Use graphic organizers/study guides	Keep classroom rules simple and clear
Use calculator	Allow time out of seat to run errands
Grammar, spelling, punctuation errors not evaluated	Contracting with student – Individual Behavior Plan
Allow someone to write answers for student	OTHER:
Not grading handwriting	1-to-1 instruction for specific goals
Shorten requirements	Projects in place of assignment
Minimize memory demands	Individual learning center
Vocabulary list prior to lessons	Credit for class participation
Repetition of explanation: practice	Use study carrel when needed
Provide copies of material copied from board	Preferential seating (describe):
Provide copies of notes from classmate	
Have students repeat directions	
Use index cards etc to track while reading	
Use highlighter to focus on directions/examples	OTHER: (Please Describe)
TESTING:	
Extra time to complete tests and quizzes (if checked, please explain):	
Tests given/taken orally with reading assistance, computer	
Shorten tests (if multiple, similar questions)	
One-on-one testing	
Assess via portfolio	
Take test in smaller setting	
Use word bank	
Retake tests below ____ % (specify)	
Provide essay questions in advance	



Modifications:

Modifications change, reduce, or lower the learning expectation. They alter what is to be learned. Modifications involve substantive changes to: the curriculum a child studies; the way a child is assessed; the type of instructional techniques used to teach the child critical skills such as reading, writing, or mathematics. The purpose of modifications is to allow children who have a specific disability or specialized educational needs an opportunity to receive necessary therapeutic or educational interventions in order to master critical skills.

NOTE: Students receiving modifications will also receive accommodations. However, students only receiving accommodations will not receive modifications.

Check all that apply. Please list additional modifications in the table below.

Ability Level Math.		
Ability Level Language Arts		
Ability Level Science		
Ability Level Social Studies		
Ability Level Spelling		
Reduce the number of multiple-choice options and simplify language		
Select standards assessed		
Audio version of novel or similar text at a lower reading level		
Verbal responses or outline in lieu of writing essay		

In attendance at the meeting:

1. Name: _____ Signature: _____

Title: _____

2. Name: _____ Signature: _____

Title: _____

3. Name: _____ Signature: _____

Title: _____

4. Name: _____ Signature: _____

Title: _____

5. Name: _____ Signature: _____

Title: _____



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School Year:
Date:

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Title: _____

5. **Name:** _____ **Signature:** _____

Title: _____