Student Information Checklist - Current Student

Student Name: _____ **Date:** _____

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

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

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

Task	*Initial/Date*	*Comments*
Student Supplemental Information Form		
Student Support Teacher Survey		
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		
Medical Professional		
Student Support Plan (if Catholic School transfer)		

Student Support: Teacher Survey

Please fill out the form as thoroughly as possible.

*Required

Your Email* _____

Student Name* _____ **Grade Level*** _____

Requested By* _____ **Date Submitted*** _____

Please fill out the steps you have already taken. Opportunities for description will follow.

- Have you spoken to the student about your concerns? * Yes No

  Please give a brief description of the conversations and the dates: *

- Have you spoken to the student's parents/guardians about your concerns? *
  - ☐ Yes, by email
  - ☐ Yes, by phone
  - ☐ Yes, face-to-face
  - ☐ No

- Please give a brief description of the conversations and the dates: *

- What specific interventions have you already tried with this student: *

- What were the outcomes of these actions? *

Please note any data collected to support your concerns (grades, observations, specific incidents, assessments, etc.) *

Level of concern: *

Monitor ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Urgent

Please circle all that apply related to ACADEMIC CONCERNS *

- ☐ Low quiz/test score
- ☐ Currently failing
- ☐ Poor work quality
- ☐ Not responsive to suggestions for help
- ☐ Requests helps, but still struggling
- ☐ Does not take notes
- ☐ Work turned in is incomplete
- ☐ Difficulty following directions
- ☐ Inability to organize or loses materials/assignments
- ☐ Struggles with attention to detail/careless mistakes
- ☐ Becomes anxious before, during, and/or after tests
- ☐ Does not willingly participate in class
- ☐ Difficulty answering when called upon
- ☐ Makes many errors reading aloud or reads aloud slowly
- ☐ Struggles to summarize passages or text
- ☐ Very poor handwriting
- ☐ Difficulty with tasks requiring memorization
- ☐ Difficulty with multi-step directions and tasks

- [ ] Counts on fingers
- [ ] Needs calculator for basic facts
- [ ] NO ACADEMIC CONCERNS

Please list any additional academic concerns not listed above:

Please circle all that apply related to BEHAVIORAL CONCERNS *

- [ ] Extremely talkative (often off-topic, extra tangential information)
- [ ] Hyperactive/impulsive
- [ ] Disruptive
- [ ] Easily distracted
- [ ] Blurts out answers/interrupts
- [ ] Constantly fidgets/ “taps” on desk
- [ ] Daydreams/does not seem to pay attention
- [ ] Falls asleep in class
- [ ] Defiant with authority
- [ ] Verbal abuse to others
- [ ] Verbal abuse to self
- [ ] Threatens violence
- [ ] Uses obscene language
- [ ] Mood swings/easily angered
- [ ] Bullies other students
- [ ] Isolates self, cries in class, puts head down, irritable

- [ ] Writes concerning notes
- [ ] Needy/clingy
- [ ] Doesn't work independently
- [ ] NO BEHAVIORAL CONCERNS

Please list any additional behavioral concerns not listed above:

Please circle all that apply related to SOCIAL/EMOTIONAL CONCERNS *

- [ ] Overreacts
- [ ] Change of friends
- [ ] Inappropriate affection
- [ ] Appetite change
- [ ] Withdrawal
- [ ] Irritability
- [ ] Excessive crying
- [ ] Change in activities
- [ ] Defensive
- [ ] Does not notice social cues
- [ ] NO SOCIAL/EMOTIONAL CONCERNS

Please list any additional social/emotional concerns not listed above:

Please circle all that apply related to PHYSICAL CONCERNS *

- [ ] Poor hygiene
- [ ] Poor coordination
- [ ] Drowsiness/slurring
- [ ] Glassy/bloodshot eyes
- [ ] Bruises
- [ ] Weight increase
- [ ] Weight decrease
- [ ] Smells of alcohol/marijuana
- [ ] Decreased athletic performance
- [ ] Complains of headaches
- [ ] Frequently sick
- [ ] Dressed inappropriately for weather (no coat, long sleeves in heat, etc.)
- [ ] NO PHYSICAL CONCERNS

Please list any additional physical concerns not listed above:

Please circle all that apply related to FAMILY CONCERNS *

- [ ] Discusses abuse
- [ ] Anger at parents
- [ ] Suffered recent loss
- [ ] Takes care of sibling daily
- [ ] NO FAMILY CONCERN

Please list any additional family concerns not listed above:

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 OBSERVATION FORM

Student: _____Grade: _____ Teacher: _____

School: _____ Date: _____

Observer: _____ Position: _____

Start Time: _____ End Time: _____ Adults: _____ Students: _____

Learning Situation Location: _____

Classroom Activity:

Signature of Observer: _____

Please add additional pages as needed.

Student Support Planning Meeting

School: _____

Student Name: _____ Date: _____

Grade: _____ Homeroom Teacher: _____

Student Strengths: (consider advocacy, social emotional, academic skill, independence, work ethic)

Student Challenges (consider advocacy, social emotional, academic skill, independence, work ethic):

Current Strategies:

Team Recommendations:

Follow-Up Plan/Persons Responsible:

Contact parents regarding meeting via ☐ call ☐ meeting ☐ email

Parent to be contacted by: _____

Date: _____

Those not in attendance needing this information:

Will be contacted by ☐ call ☐ meeting ☐ email

Date: _____

Follow Up Student Planning Meeting Date: _____

Additional Comments:

Student Intervention Plan

School Year: _____

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

School: _____ Grade: _____ Meeting Date: _____

Evaluation Date: _____ Evaluator: _____

Support Team Manager:

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

Student strengths/ways to implement during the school year:

Please add additional pages if needed.

Pre-Evaluation Referral Checklist

- [ ] I have observed the behavior/skill in question and have notes/records of my observations.

- [ ] I have assembled samples of this student's work relevant to the behavior/skill in question, including samples of the work done by a typical student in my class.

- [ ] I have had at least one informal conversation with a colleague at my school to brainstorm ideas that might solve the problem.

- [ ] I have had regular contact with the student's parent(s) in regard to the skill/behavior in question.

- [ ] I have asked the parent(s) basic questions about vision, hearing, sleep habits and diet to ensure that none of these is the cause of the problem. (If there is a doubt, the child should see their pediatrician before considering a referral.)

- [ ] I suggested to the parent(s) some simple things they can try at home to alleviate this problem. (Parents may or may not follow through; however, the suggestions have been made. These might include supervising homework, simple behavior management strategies, talking to the child about the importance of following classroom rules, etc.)

- [ ] If appropriate, I have asked a teacher who teaches the same grade, the school counselor, the school support teacher, or the principal to do a formal observation of the child in a situation likely to demonstrate the problem in question.

- [ ] I can articulate several pre-referral interventions that I have specifically tried with this student to alleviate the need for referral. I have made particular note of strategies that may have been at least partially successful.

- [ ] When possible, I have spoken to a teacher who taught this child last year to see if a similar problem existed, and to gain ideas on what has worked in the past.

- [ ] I have read the information in the child's permanent folder to see if there is anything relevant to the situation contained there.

Student Intervention Plan

School Year: _____

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

School: _____ Grade: _____ Meeting Date: _____

Evaluation Date: _____ Evaluator: _____

Support Team Manager: _____

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

Student strengths/ways to implement during the school year:

Please add additional pages if needed.

Student Intervention Tracking Form

Student Name:		Student Grade:		Student DOB:	
Goal	**Intervention**	**Duration**	**Frequency**	**Evidence of Progress**	**Teacher Responsible**

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:

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.

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		

Student Support Meeting Notes/ Signatures of Attendance

Student: _____ **Meeting Date:** _____

Notes:

Please use additional pages if needed.

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: _____