STUDENT SUPPORT TEAM PROCESS

When a student is experiencing difficulty in school, it is necessary to identify the cause and provide appropriate intervention strategies as early as possible. In order to accurately assess the problem it is important to gather as much data as possible and seek input from individuals with knowledge about the student before making a determination to implement a particular program or strategy. Each campus will utilize a Student Support Team to review all available data and make programmatic recommendations. Program decisions will be made after allowing adequate time to evaluate the effectiveness of intervention strategies. The Principal will oversee the final decision process.

All deliberations and data gathered by the Student Support Team are confidential. They may be shared with appropriate committees to whom a recommendation is made to aid in determination of services.

Student Support Teams will consist of at least the following:

- Campus Principal
- Campus Counselor
- Referring Teacher
- Parent/Guardian
- Interventionists
- Special education teacher

Others who may be included:

- Other professionals who may have specific knowledge of the student
- Diagnostician to assist in analyzing data prior to referral (required beginning at second meeting)
- School nurse
- Reading Coach

1. Any student who experiences difficulty in school after implementation of minor accommodations and/or Tier 1 interventions in the regular classroom should be referred to the Student Support Team.
2. Students exhibiting behaviors which cause the teacher to suspect emotional or chemical related problems should be referred to the SST.
3. Following AIMSweb Benchmark assessments, the SST will meet to analyze data and make recommendations for appropriate levels of intervention for students identified as struggling in math or reading. Students identified for intervention through the AIMSweb system will follow the flow chart for tier placement and Response to Intervention evaluation prior to any program referral.
4. Student Support Teams review all data and make the appropriate recommendations. Data to be considered includes:
   - AIMSweb Benchmark and Progress Monitoring Reports
   - Grades
   - State Assessment data
   - Attendance, discipline, health, or other pertinent school related data
   - Information from parents, specialists, and other professionals
5. The Student Support Team may recommend any of the following:
   - Continue Tier 2 Intervention Program
   - Modify duration intensity, or delivery of Tier 2 Intervention Program
   - Additional strategies in general education
   - ESL or Bilingual program for evaluation and appropriate services
   - Evaluation by the counselor and/or appropriate services
   - Referral for speech assessment only
   - Referral to the nurse for additional health screening.
   - Dyslexia Program for further evaluation and appropriate services
   - Section 504 Committee evaluation
   - Referral to Special Education for evaluation and appropriate services

6. If a referral to Special Education is determined to be the best action, copies of the Teacher Form and Committee Worksheet, SST Parent Interview, SST Nurse Form, and SST Principal Form are to be included with the HONDA referral packet when it is completed and submitted. In addition, copies of all data considered by the Student Support Team in making the recommendation must be included.

Student Support Teams

DO NOT begin a referral (with the exception of the obvious severe issues) without going through the SST process and documenting your efforts to intervene.

Purpose:

- Team problem solving model in which a team meeting is scheduled as soon as a difficulty is noticed with behavior, academics, grades, etc.
- Meetings must be scheduled keeping in mind ARD schedules
- Team approach to data analysis
- MAY be a referral avenue following a minimum of 3 SST meetings with diagnosticians required beginning at the second meeting.
- SST meetings include everyone who has knowledge of the student in order to bring all data to the table.
  - principal, counselor, parents, and teachers are required
  - interventionist, special ed teachers are necessary to provide data
  - nurse may be appropriate if the issue is medical
  - Law enforcement officer may be appropriate
  - FOCUS teacher for some students
  - anyone who can assist in finding solutions should attend
  - diagnosticians must be involved before a referral is requested
- All staff must know how to request an SST meeting

Timing is everything. The earlier a problem is identified and intervention provided, the greater the chances of success.
SST agendas, minutes, copies of data, etc. are required for referrals to any special program (dyslexia, 504, special education)

Remember – If you suspect eligibility for special education, the obligation is still to refer. If a disability is obvious or severe, you would not wait. This is a legal requirement.

Required documentation:

- SST Parent Interview
- SST Teacher Form including Student Interventions/Strategies
- SST Nurse Form SST
- Observation Data
- Progress Monitor or Strategic Monitor Data
Teacher contacts parent and Principal; Preliminary strategies are planned by teacher or grade level team

**Tier 1** Interventions are implemented by classroom teacher

**PROBLEM RESOLVED**
- Monitor & consult

**Problem Not Resolved**
- Teacher requests SST packet from Counselor
- Teacher completes packet and returns to Counselor
- Counselor or Principal schedules SST

**SST Meets**
- Include parent when possible
- Consider implementation of additional intervention strategies
- Specific Program Changes (Dyslexia, Speech)

**Plan Working:**

**Plan Not Working:**
- Schedule another SST meeting

Parent, Diagnostician, Interventionist, and special education teacher must be involved

**SST Considers:**
- Adjusting duration, intensity, or delivery of the current program
- Referral to 504
- Referral to Special Education
- Referral to other special program
AIMSweb Assessment Flow Chart

Universal Screening for All Students
Data Meeting to Identify Students in Need of Intervention
Review Intervention/Strategy Form

Tier 1
10th-25th Percentile
Tier 1 Intervention with classroom teacher
Strategic Monitor Monthly

Review at 8 weeks
• Continue program and monitor
• Refer to Tier 2 for additional intervention
• Dismiss if goals are met

Tier 2
0-10th Percentile
Tier 2 Intervention with Specialist
Progress Monitor Weekly or Bi-Weekly

Review at 8 weeks
• Continue program if progress is seen
• Return to Tier 1 if goals are met
• Refer to SST if program isn’t successful

TIER 3
• Special Education Instructional Setting
Referral to Special Program Checklist

Student:____________________________________

Campus:____________________________________

Date:_____________________________________

______SST Confidential Parent Interview

______SST Teacher Form

______Copy of the original Home Language Survey

______Copy of the most current report card

______Copy of the most recent testing results (TPRI, TAKS, ITBS, TELPAS, etc.)

______Student Observation Data

______Student Interventions/Strategies Form

______SST Confidential Nurse Form

______SST Committee Deliberations

______Principal Form

______Response to Intervention Documentation
STUDENT INTERVENTION TEAM
(PARENT REQUEST FOR SPECIAL EDUCATION TESTING)

Student Name __________________________SS # ____________________
DOB ___________ Grade ________ School __________________________

Parent(s) Father __________________________
Phone (home) ___________________________(work) ________________________
Address ____________________________________________
Mother ________________________________
Phone (home) ___________________________(work) ________________________
Address ____________________________________________

I am requesting that ____________________________ be referred to the intervention team for review of his/her educational program. The review is requested because: [include behaviors observed at home, academic strengths/weaknesses noted during homework completion, strategies attempted to correct the problem at home and in conjunction with the classroom teacher/s).

________________________________________

Has the classroom teacher indicated concerns about your child's academic performance? Yes / No. If yes, please list concerns

________________________________________

________________________________________

What classroom instructional strategies do you think would help your child?

________________________________________

Has your child had any previous evaluations through any school system or private provider? _ If yes, does the school have a copy of that evaluation? ___________ Who conducted the evaluation and when__________

________________________________________

I would like for my child to begin the General Education Intervention process immediately.

________________________________________ Date

Parent/s Signature

(OR)

The principal has explained the Response to Intervention process to me in detail. I understand the process but wish to skip all interventions and have my child tested for special education. I understand that the process is in place to help prevent my child from being labeled as a child with a disability. (GIVE COPY OF PROCEDURAL SAFEGUARDS). Begin the referral packet process.

________________________________________ Date

Parent/s Signature
# Student Support Team
## Confidential – Teacher Form & Committee Worksheet

### Student Data

<table>
<thead>
<tr>
<th>Name of Student</th>
<th>Date</th>
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<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
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<table>
<thead>
<tr>
<th>Present grade in school</th>
<th>Campus</th>
<th>Homeroom</th>
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<table>
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<tr>
<th>Name of person(s) initiating intervention:</th>
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<table>
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<tr>
<th>Reason for referral to SST:</th>
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</table>

### School Data

<table>
<thead>
<tr>
<th>Days absent this year</th>
<th>Is absenteeism a problem this year?</th>
<th>Yes</th>
<th>No</th>
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<tr>
<th>Has Absenteeism been a problem in previous years?</th>
<th>Yes</th>
<th>No</th>
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<tr>
<th>Has student been retained?</th>
<th>Yes</th>
<th>No</th>
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<tr>
<th>If yes, which grade(s)?</th>
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</table>

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<thead>
<tr>
<th>Has the teacher contacted the parent about concerns before this meeting?</th>
<th>Yes</th>
<th>No</th>
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<tr>
<th>Number of discipline referrals:</th>
</tr>
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<tr>
<th>Attach copies of discipline referrals.</th>
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</table>

### Fine and Gross Motor Skills

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<tr>
<th>Fine Motor Skills:</th>
<th>Poor</th>
<th>Good</th>
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<td>_____</td>
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<table>
<thead>
<tr>
<th>Gross Motor Skills:</th>
<th>Poor</th>
<th>Good</th>
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<td>_____</td>
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<tr>
<th>_____ Average</th>
<th>_____ Average</th>
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<table>
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<tr>
<th>_____ Superior</th>
<th>_____ Superior</th>
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**Teacher Form p. 1**
Language

Child’s most efficient mode of communication:  Oral     Sign Language     Other: ____________________________

Student has Limited Proficiency in English      Yes      No      If yes, please attach a copy of TELPAS results and ESL testing.

Language constitutes a barrier to learning (limited English spoken at home).      Yes      No

Expressive Language Skills:  Poor     Average     Superior     Receptive Language Skills:  Poor     Average     Superior

Behavioral Observations

Rate this student’s behavior in relation to their peers. For each behavior, mark:

1 = Poor      2 = Below Average     3 = Average     4 = Above Average     5 = Superior     N = Not observed

Generally cooperates or complies with teacher requests 1 2 3 4 5 N
Adapts to new situations without getting upset 1 2 3 4 5 N
Accepts responsibility for his / her own actions 1 2 3 4 5 N
Makes and keeps friends at school 1 2 3 4 5 N
Works cooperatively with others 1 2 3 4 5 N
Has an even, usually happy, disposition
Never      Sometimes      Usually      Always
Appropriate attention and concentration 1 2 3 4 5 N
Complies with teacher directives 1 2 3 4 5 N
Brings necessary materials to class 1 2 3 4 5 N
Fidgets, squirms, or seems restless:
Never      Sometimes      Usually      Always
Completes tasks on time 1 2 3 4 5 N
Stays on task 1 2 3 4 5 N
Student is easily redirected 1 2 3 4 5 N
Remains seated 1 2 3 4 5 N
Takes turns, waits for turn (For younger students) 1 2 3 4 5 N
Behaves in a manner appropriate for the situation 1 2 3 4 5 N
Student exhibits extreme mood changes:
Never      Sometimes      Usually      Always
Student responds appropriately to praise and correction 1 2 3 4 5 N
Other information:__________________________________________________________________________________

Place a mark beside the areas in which the student is experiencing difficulties:

Attention: _______  Self Control: ____________  Self Concept: ____________
Respect for Authority: ____________  Respect for Peers: ____________

Teacher Form p. 2
Academics

☐ Has difficulty understanding abstract concepts
☐ Needs oral questions and directions frequently repeated
☐ Has difficulty retrieving and recalling information
☐ Requires slow, sequential, substantially broken down presentation of concepts
☐ Fails to remember sequences
☐ Distorts or mispronounces words or sounds when speaking (not attributed to dialect or accent)
☐ Has difficulty comprehending what he/she reads
☐ Difficulty in copying letters, words, sentences, and numbers from a model
☐ Uses inappropriate spacing between words or sentences when writing
☐ Does not compose complete sentences or express complete thought when writing
☐ Fails to change from one math operation to another
☐ Fails to follow necessary steps in math problems
☐ Is unable to perform assignments independently
☐ Does not perform or complete classroom assignments on items
☐ Requires repeated drill and practice to learn what other students master easily
☐ Other (list)
☐ Other (list)

Instructional Rating
Rate the concerns you have about this student. For each skill, circle the appropriate rating.

1 = Poor  2 = Below Average  3 = Average  4 = Above Average  5 = Superior  N = Not observed

Basic Reading  Math Calculation
1 2 3 4 5 N
Reading Comp. Math Problem Solving
1 2 3 4 5 N
Written Expression  Follows Written Directions
1 2 3 4 5 N
Spelling  Follows Oral Directions
1 2 3 4 5 N
Homework  Organizational Skills
1 2 3 4 5 N

Attempted Interventions

☐ Bilingual/ESL
☐ Tutorials _________________________________
☐ Counseling _________________________________
☐ Parent Contact/Assistance______________________________
☐ Office Referrals ________________________________
☐ Classroom Accommodations Implemented ________________________________
☐ Modified Assignments ________________________________
☐ Redirection
☐ Other (list) __________________________________________
☐ Other (list) __________________________________________

Teacher Form p. 3

Student Study Team Forms revised 08/2010
Student Interventions/Strategies Documentation

<table>
<thead>
<tr>
<th>Strategies/Interventions</th>
<th>Results</th>
<th>Dates To/From</th>
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<tbody>
<tr>
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Interventions may include:

- Explicit and systematic small group instruction
- Supplemental instruction provided using a different instructional strategy
- Additional practice activities
- Instruction targeting specific areas of weakness

Teacher Form p. 4
SST Deliberations

__________________________________________________________________________________________________
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__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Conclusions

What needs to happen with this student that is not happening? ____________________________________________
__________________________________________________________________________________________________
What are our goals for this student?
__________________________________________________________________________________________________
__________________________________________________________________________________________________
What will we do now? ________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Next meeting date: ____________________________
Parent Information Form

<table>
<thead>
<tr>
<th>Name of Student</th>
<th>Date of Birth</th>
<th>Ethnicity</th>
<th>Gender: M / F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Address</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>Mailing Address</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
</tr>
</tbody>
</table>

School / Campus | Grade | Is the student eligible for Medicaid? | Yes | No | Student’s Medicaid Number: _________________

Home Phone #: E-Mail: ____________________________
Work Phone #: Cell Phone #: _______________________
Emergency Contact: Cell Phone #: ___________________
Emergency #: ________________________________

Name of person answering questions: ________________________________

Relationship to student: ________________________________

Who has legal authority to make educational decisions for this child? ________________________________

Do both parents live in the student’s home? Yes | No | If not, with whom does the student live?
Name: ________________________________ Relationship: ________________________________

Parent’s education level: Father: ________________________________ Mother: ________________________________

<table>
<thead>
<tr>
<th>Name of Father</th>
<th>Address (if different from above)</th>
<th>State</th>
<th>Zip Code</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Mother</td>
<td>Address (if different from above)</td>
<td>State</td>
<td>Zip Code</td>
<td>Occupation</td>
</tr>
</tbody>
</table>

What primary language is spoken in the home? English | Spanish | Other: __________________

How long has the student lived in the United States? ________________________________

If parent/guardian works outside of home, please provide the following information:

Who cares for this child when the parent/guardian is gone? ________________________________

What language does the caregiver speak? English | Spanish | Other: __________________

Have there been any important changes within the family during the past three years? For example: job changes, moves, births, deaths, illnesses, separations, or divorce.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
### OTHER CHILDREN IN THE HOME

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Relationship to Student</th>
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<td>M</td>
<td>F</td>
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<td>M</td>
<td>F</td>
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<td>F</td>
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<td></td>
<td></td>
<td>M</td>
<td>F</td>
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</tbody>
</table>

Do any of these children have learning problems? Yes [ ] No [ ] If yes, please specify:
________________________________________________________________________________________
________________________________________________________________________________________

### OTHER ADULTS IN THE HOME

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Relationship to Student</th>
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<td>M</td>
<td>F</td>
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<td>M</td>
<td>F</td>
</tr>
</tbody>
</table>

Do any other family members have learning problems? Yes [ ] No [ ] If yes, please specify:
________________________________________________________________________________________
________________________________________________________________________________________

Yes [ ] No [ ] Does the student eat breakfast regularly?

What time does the student go to bed at night? _________

Check the activities in which this child regularly participates either alone or with the family:

<table>
<thead>
<tr>
<th></th>
<th>Alone</th>
<th>w/ Family</th>
<th>Alone</th>
<th>w/ Family</th>
<th>Alone</th>
<th>w/ Family</th>
</tr>
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<tbody>
<tr>
<td>Reads books</td>
<td>☐</td>
<td>☐</td>
<td>Play outside</td>
<td>☐</td>
<td>☐</td>
<td>Plays w/friends</td>
</tr>
<tr>
<td>Computer</td>
<td>☐</td>
<td>☐</td>
<td>Trips</td>
<td>☐</td>
<td>☐</td>
<td>Team sports</td>
</tr>
<tr>
<td>Movies</td>
<td>☐</td>
<td>☐</td>
<td>Meals</td>
<td>☐</td>
<td>☐</td>
<td>Internet</td>
</tr>
<tr>
<td>Games</td>
<td>☐</td>
<td>☐</td>
<td>Church</td>
<td>☐</td>
<td>☐</td>
<td>Part-time job</td>
</tr>
<tr>
<td>Television</td>
<td>☐</td>
<td>☐</td>
<td>Video games</td>
<td>☐</td>
<td>☐</td>
<td>Extra Curricular</td>
</tr>
</tbody>
</table>

What are your child’s strengths?
________________________________________________________________________________________
________________________________________________________________________________________

What level of education do you hope your child will complete? Circle the choice.

- High School
- Technical / Vocational School
- College
- Law / Medical, other advanced studies

Student Study Team Forms revised 08/2010
**STUDENT BEHAVIOR**

Describe the student’s behavior at home, with peers, siblings, neighbors, and parents. (For example, is the child generally well behaved, passive or aggressive, social or a loner, affectionate or withdrawn, etc.

________________________________________________________________________________________

________________________________________________________________________________________

Please indicate how this child relates to other children: Circle the answer for each question.

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<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Has problems relating to or interacting with peers</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Fights frequently with peers</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Prefers playing with younger children</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Prefers to spend time alone</td>
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</table>

Please indicate whether this child exhibits any of the following behaviors:

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<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Is easily over-stimulated</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Has a short attention span</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Seems overly energetic</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Seems impulsive</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Overreacts when faced with a problem</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Seems uncomfortable meeting new people</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Requires a lot of parental attention</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Lacks self-control</td>
</tr>
</tbody>
</table>

Who is mainly in charge of discipline in the home? ______________________________________________

Describe discipline techniques and their effectiveness (time out, spanking, rewards, extra chores)

________________________________________________________________________________________

How does the child respond to discipline? _____________________________________________________

**EDUCATIONAL HISTORY**

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<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Did/does this child attend kindergarten?</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Were there any problems in kindergarten? Describe: ________________________________</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Has this child been retained a grade in school? If yes, when and why?</td>
</tr>
</tbody>
</table>

________________________________________________________________________________________

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<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Does your child have problems in school? If yes, please explain.</td>
</tr>
</tbody>
</table>

________________________________________________________________________________________

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Has this child been previously tested for special education? If yes, when? ___________</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Has this child received special education services in the past? If yes, please explain:</td>
</tr>
</tbody>
</table>

________________________________________________________________________________________
Yes  No  Is your child absent from school frequently? If yes, why and about how often?
________________________________________________________________________________________

What does your child like about school?  ____________________________________________________

**HEALTH HISTORY**

Yes  No  Were there any complications with the pregnancy or child birth including premature labor / birth?  
*If yes, please explain.*
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Yes  No  Is this child under the care of a physician for a medical problem? If yes, please describe:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Yes  No  Is this child currently taking medication or has this child ever taken medication for a long period of time? If yes, please explain:
________________________________________________________________________________________

Yes  No  Does your child appear to have any other physical health problems, including allergies? If yes, please explain.  __________________________________________________________

Yes  No  Has this child ever had a head injury? If yes, explain:
________________________________________________________________________________________

Yes  No  Has this child ever had ear infections, hearing problems or ear tubes? If yes, explain:
________________________________________________________________________________________

Yes  No  Has this child ever worn glasses / contacts or had vision problems? If yes, explain:
________________________________________________________________________________________

List any hospitalizations and / or serious illnesses for this child:
________________________________________________________________________________________
________________________________________________________________________________________
Complete this section for students that are under 6 years of age.

<table>
<thead>
<tr>
<th>Does your child have or has he/she had any of the following:</th>
<th>Yes</th>
<th>No</th>
<th>Began at age:</th>
<th>Stopped at age:</th>
<th>Continues to have:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent fevers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Frequent earaches</td>
<td></td>
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<td></td>
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<tr>
<td>Frequent vomiting</td>
<td></td>
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<tr>
<td>Frequent headaches</td>
<td></td>
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<tr>
<td>Thumb sucking</td>
<td></td>
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</tr>
<tr>
<td>Sleep difficulties</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Head banging</td>
<td></td>
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<tr>
<td>Rocking of body</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Teeth grinding</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temper tantrums</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lost consciousness</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Convulsions (seizures)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Weight problems</td>
<td></td>
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<tr>
<td>Walking difficulties</td>
<td></td>
<td></td>
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<tr>
<td>Difficulty learning to ride a bike</td>
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<tr>
<td>Difficulty learning to skip</td>
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<tr>
<td>Difficulty learning to throw or catch</td>
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<tr>
<td>Separating from parents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nightmares</td>
<td></td>
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<tr>
<td>Sleepwalking</td>
<td></td>
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<tr>
<td>Bedwetting/soiling</td>
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</tr>
<tr>
<td>Nail biting</td>
<td></td>
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</tr>
</tbody>
</table>

______________________________  ________________
Signature of Parent       Date

______________________________  ________________
Signature and position of person completing this form  Date

______________________________  ________________
Signature of Interpreter, if necessary                Date

Student Study Team Forms revised 08/2010
CONFIDENTIAL – NURSE FORM

Student Name ________________________________

Health Information (Vision and hearing tests must have been administered within the current year)

Does Student wear Glasses/Contacts: Yes     No

*Vision:

Date of Vision Screening: ____________

Distance Vision Assessment
Right Eye ________
Left Eye: ________
Both eyes ________

Near Vision Assessment
Right Eye ________
Left Eye: ________
Both eyes ________

Date of second screening ________________

Distance Vision Assessment
Right Eye ________
Left Eye: ________
Both eyes ________

Near Vision Assessment
Right Eye ________
Left Eye: ________
Both eyes ________

Is additional assessment recommended? No Yes ______________________________________________________

*Hearing:

Date Tested: ________________

Right Ear: Pass Fail  Left Ear: Pass Fail

Date of second screening: ________________

Right Ear: Pass Fail  Left Ear: Pass Fail

Is additional assessment recommended: No Yes  ______________________________________________________

Is the student taking any medications at school? No Yes If yes, please list medications and possible side effects caused by the medications: ________________________________

Is student currently taking any additional medications? No Yes If yes, please list medications and possible side effects caused by the medications: ________________________________

Does the student exhibit any medical/physical problems? Yes No

If yes, please list: ________________________________
Nurse completing information: ____________________________________________

Student Support Team
Confidential - Principal Form

Student Name__________________________________________________________

Person Initiating Intervention____________________________________________

Date Packet Given to Teacher: _____________ Date Returned _____________

After reviewing the information, the Student Support Team recommends the following action(s):

- Problem resolved, discontinue intervention and monitor
- Continue with Tier 2 Intervention
- Modify duration, intensity, or delivery of Tier 2 Intervention Program
- Additional strategies in general education
- ESL program for evaluation and appropriate services
- Evaluation by counselor for appropriate services
- Referral for speech assessment only
- Dyslexia Program for evaluation and appropriate services
- Section 504 evaluation
- Referral to Special Education for evaluation and appropriate services
- Referral to nurse for medical screening

- Other: __________________________________________________________________

- Justification of educational need: _______________________________________

________________________________________________________________________

________________________________________________________________________

Signatures:

_________________________ ________________________________
Principal Counselor

_________________________ ________________________________
Referring Teacher Other

_________________________ ________________________________
Other Date

Student Study Team Forms revised 08/2010
Student Support Team Minutes

SST Deliberations: Date ________________________________

Conclusions

What needs to happen with this student that is not happening? ________________________________

________________________________________

What are our goals for this student? ________________________________

________________________________________

What will we do now? ________________________________

________________________________________

Next meeting date: ________________________________
HONDA SHARED SERVICE ARRANGEMENT
STUDENT OBSERVATION DATA

STUDENT__________________________________________ CLASSROOM TEACHER __________________________

OBSERVER________________________________________ POSITION______________________________________

TODAY’S DATE_________________ TIME OF DAY__________________________________________________________

This observation must be completed by someone other than the student’s referring classroom teacher. The class observed must be related to the student’s problem area.

GENERAL OBSERVATIONS:

Subject__________________________________________ Pupil/Teacher Ratio__________________________

CLASSROOM ARRANGEMENT:

Row of Desks_______ Grouped Desks_________ Tables___________ Centers_________

Other____________________________________________

INSTRUCTIONAL ORGANIZATION/ACTIVITY:

_____ Whole class     _____ small group     _____ learning center      _____ group discussion

_____ Direct instruction     _____ one-on-one     _____ guided practice      _____ independent practice

CHECK ITEMS THAT DESCRIBE THE STUDENT’S CLASS BEHAVIOR AND ATTITUDE DURING THE OBSERVATION:

YES  NO  YES  NO

_____  _____ Attentive / on-task

_____  _____ Polite

_____  _____ Cooperative

_____  _____ Organized

_____  _____ Works independently

_____  _____ Follows oral directions

_____  _____ Follows written directions

_____  _____ Completes written tasks in allotted time

_____  _____ Accepts assignments without complaints

_____  _____ Interacts appropriately with peers

_____  _____ Participates appropriately in class

_____  _____ Easily distracted

_____  _____ Needs frequent redirection

_____  _____ Disruptive

_____  _____ Talkative

_____  _____ Speaks out without permission

If yes, how many times?__________________

_____  _____ Out of seat without permission

If yes, how many times?__________________

Student Study Team Forms revised 08/2010
CHECK ITEMS THAT DESCRIBE THE QUALITY OF THE STUDENT’S WORK:

YES  NO

Completes assignments with accuracy

Turns work in on time

Completes work neatly / writes legibly

OBSERVED BEHAVIOR:

YES  NO

The student evidenced deficits in listening comprehension.

The student evidenced deficits in reading comprehension.

The student had difficulty finding the right words when speaking.

The student had difficulty writing spontaneously, as shown by the inability to formulate sentences and paragraphs.

The student had difficulty identifying / using strategies for solving math problems.

The student functions adequately in the classroom with modifications.

The student has difficulty understanding assignments.

The student appears to be functioning significantly differently than peers academically.

The student appears to be functioning significantly differently than peers socially.

WHAT BEHAVIOR CONCERNS DO YOU HAVE ABOUT THIS STUDENT BASED ON THE STUDENT’S HISTORY?

Poor attention and concentration

Noncompliance with teacher directives

Excessively high/low activity level

Difficulty following directions

Easily frustrated

Extreme mood swings

Difficulty working with peers

Difficulty staying on task

Other

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