

Grade: _____ **Referring Teacher:**_____ **School:**_____

➤ If more than 2 interventions are needed document all additional interventions on a PST8 and PST 9 forms.

Calhoun County Schools
Problem Solving Team Timeline for Students with Cognitive Concerns (InD referrals)

Student: _____ DOB: _____ ID: _____

Grade: _____ Referring Teacher: _____ School: _____

Date: _____ Forms for referring teacher:

- _____ **PST 1** Complete this form to identify concerns of the student.
- _____ **Student Progress Profile** Complete *Student Progress Profile* form on page 6; attach reports.
- _____ **PST 2** Complete this form each time an informal parent contact is made.
The referring teacher should have at least two informal contacts before meeting with the team.
- _____ **PST 2** Second informal parent contact is made.
The referring teacher should have at least two informal contacts before meeting with the team.
- _____ **PST 3** Complete this observation form of the student's performance, behaviors, and interactions.
When more than one teacher is providing instruction to the student, teachers with concerns about the student's performance in their content area should complete a PST 3. (i.e. reading teacher, math teacher, language arts/English teacher)
- _____ **PST 4** Complete this form only if there are speech concerns in addition to other concerns.
- _____ **PST 5** Have the parent/guardian of the student sign the consent form for screening.
- _____ **PST 7** Complete this form only if there are behavior concerns.
- _____ **The previous forms must be completed before giving the Rtl folder to the Guidance Counselor.**
- _____ **Rtl Folder given to Guidance Counselor** - Based on input from teacher and parent, the Guidance Counselor will determine which screenings should be completed with the student. (Vision and hearing screenings must be completed for all referrals.)

Date: _____ Forms for support staff to complete:

- _____ **PST 6** Vision/Hearing Screening completed by School Nurse
- _____ **PST 6** Speech and/or Language Screening completed by Speech /Language Therapist (if speech and/or language is area of concern)
- _____ **PST 6** Vanderbilt Behavior Screening completed by Guidance Counselor (if behavior is area of concern)
- _____ **PST 6** Cognitive Screening completed by Guidance Counselor

Date: _____ Forms completed by the Guidance Counselor for Formal Evaluations:

- _____ **Guidance Counselor will set date for first Problem Solving Team Meeting**
- _____ **PST Meeting Invitation** If cognitive concerns are confirmed by the screening, a formal parent meeting must be scheduled to discuss concerns and the formal evaluation process. Send meeting invitation to parent or contact by phone.
- _____ **Problem Solving Team Meeting Summary** completed by the guidance counselor at meeting.
- _____ ****PST 10** If the team recommends any type of formal evaluation, this form must be signed by the parent.
- _____ **-- OR --**
- _____ **ESE 19** Use this form only if the student is already enrolled in an ESE program, an ESE 19 Consent for Reevaluation must be completed instead of a **PST 10** for formal evaluations. (Complete "**Meeting Participation Statement**" Form)
- _____ **PST 11** All PST 10 and ESE 19 forms must be accompanied by a PST 11 Referral for Formal Evaluation and signed by all team members.
- _____ **ESE 7** Social/Developmental History is a formal evaluation and must be completed at this meeting.
- _____ Send completed RTI folder to the ESE Director if a formal evaluation is requested.
- _____ ****Immediately send the PST 10 evaluation and the completed Rtl folder to the ESE Director when the parent/guardian has given consent for evaluation. The 60 day timeline begins on the day the initial consent for evaluation form (PST 10) is signed by the parent.**

Calhoun County Schools
Referral Checklist for Students with Physical/Health Concerns

Student: _____ DOB: _____ ID: _____

Grade: _____ Teacher: _____ School: _____

Date: _____ Forms for referring teacher to complete:

- _____ **PST 1** Complete this form to identify concerns of the student.
 _____ **Student Progress Profile** Complete *Student Progress Profile* form on page 6; attach reports.
 _____ **PST 2** Complete this form each time an informal parent contact is made.
 _____ **PST 3** Complete this observation form of the student's performance, behaviors, and interactions.
 _____ **PST 5** Have the parent/guardian of the student sign the consent form for screening.
 _____ **The previous forms must be completed before giving the Rtl folder to the Guidance Counselor.**
 _____ **Rtl Folder given to Guidance Counselor** - Based on input from the teacher and parent, the Guidance Counselor will determine which screenings should be completed with the student. (Vision and hearing screenings must be completed for all referrals.)

Date: _____ Forms for Support Staff to complete:

- _____ **PST 6** Vision/Hearing Screening completed by School Nurse
 _____ **PST 6** Speech/Language Screening completed by Speech/Language Therapist (if speech and/or language is area of concern)
 _____ **PST 6** Vanderbilt Behavior Screening completed by Guidance Counselor (if behavior is area of concern)

Date: _____ Forms for Guidance Counselor to complete:

- _____ **Meeting Invitation** for PST meeting sent to parent by Guidance or (contact by phone)
 _____ **Problem Solving Team Meeting Summary** completed by the guidance counselor at meeting
 _____ ****PST 10** Have the parent sign the consent for evaluation to assess academic areas
 _____ **-- OR --**
 _____ **ESE 19** Use this form only if the student is already enrolled in an ESE program, an ESE 19 Consent for Reevaluation must be completed instead of a **PST 10** (Complete "**Meeting Participation Statement**" Form)
 _____ **ESE 12C Physician's Certification of Physical Impairment** (This is considered a formal evaluation.)
 _____ Give this form to the parent/guardian to have the student's physician complete.
 _____ **ESE 22 Release of Information** Have the parent/guardian sign this form to allow the request of medical records.
 _____ **PST 11** All PST 10 forms must be accompanied by a **PST 11 Referral for Formal Evaluation** and signed by all team members.
 _____ **ESE 7** Social/Developmental History is a formal evaluation and must be completed at this meeting.
 _____ Date referral folder completed
 _____ Date referral folder sent to the ESE Director
 _____ Date referral folder received in the ESE office
 _____ Date referral folder given to School Psychologist
 _____ Date of Evaluation
 _____ Completed evaluation and referral folder returned to ESE Director by School Psychologist

Statement of Eligibility: _____ Qualifies for Other Health Impaired _____ Does not qualify for OHI

Calhoun County Schools
Gifted Referral Checklist

Student: _____ DOB: _____ ID: _____

Grade: _____ Referring Teacher: _____ School: _____

Date: _____ **Form for referring teacher:**

Student Progress Profile Complete a profile for the student for the current school year.
If it is the beginning of the school year a profile may be completed for the previous school year.

Date: _____ **Forms for Guidance Counselor to complete:**

_____ **Meeting Invitation** for first meeting sent to parent by Guidance (or notify by phone)

_____ **Meeting Summary** completed by guidance counselor at the parent meeting

_____ **PST 5** Have parent/guardian sign consent for screening.

_____ **PST 6** Cognitive screener completed by guidance counselor

_____ Meeting Invitation completed by guidance counselor for follow-up meeting (or notify by phone)

_____ Meeting Summary completed by guidance counselor summarizing results of cognitive screener.

_____ **PST 10** Have the parent sign this form for permission to complete the Gifted Characteristic Checklist and the Individual Intellectual Evaluation if team recommends full evaluation or parent requests full evaluation.

_____ Complete "**Meeting Participation Statement**" Form

_____ **ESE 6 Gifted Referral Checklist** completed by the student's teacher

_____ **PST 11 Referral for Formal Evaluation** signed by all team members

*Immediately send the PST 10 evaluation and the completed RTI Folder to the ESE Director when the parent/guardian has given consent for evaluation. The 60 day timeline begins on the day the initial consent for evaluation form (PST 10) is signed by parent.

_____ Date Gifted referral folder completed

_____ Date Gifted referral folder sent to the ESE Director

_____ Date Gifted referral folder received in the ESE office

_____ Date Gifted referral folder given to School Psychologist

_____ Date of Evaluation

_____ Completed evaluation and referral folder returned to ESE Director by School Psychologist

Statement of Eligibility: _____ Qualifies for Gifted _____ Does not qualify for Gifted

Student Progress Profile Form

Student: _____

After reviewing data from reports below, enter comments on PST 1.

Compile data from reports listed below that apply to your student and create a student profile. Conduct dataanalysis and look for patterns, trends, a root cause of the problem; identify with evidence your targeted area or specific student deficit. (Refer to MTSS/RTI Handbook for more information on data analysis and problem solving.)

Print, attach reports and bring to MTSS/RTI Meeting. If you need help finding any of the reports listed below, ask your Guidance Counselor, MTSS School Coordinator or Curriculum Coach for assistance. Duplicate reports will not be maintained in the MTSS RTI Folder.

Report	Date Pulled	Notes
Pull from FOCUS <ul style="list-style-type: none"> Florida Reports EWS PAEC RTI Student Progress Profile Report 		
i-Ready Diagnostic Assessment Data w/Scale Score		
i-Ready Growth Monitoring reports for ELA/Reading and Math		
Parent Letter; Class Summary or Student Report w/Ability Scores (9-12)		
STAR Math		
STAR Reading		
STAR Early Literacy		
Other: _____ _____		

Calhoun County Schools
Student Data Collection: Cumulative Review

PST 1

Student: _____ Grade: _____ School: _____

	YES	NO	COMMENTS
Attendance Concerns (Tardies/Absences)			
Family Factors			
Multiple school enrollment history			
Vision concerns If yes, PST 5 Screening form needed			
Hearing concerns If yes, PST 5 Screening form needed			
Speech concerns If yes, PST 5 Screening form needed			
Language concerns If yes, PST 5 Screening form needed			
Academic concerns If yes, PST 5 Screening form needed			
Behavior concerns If yes, PST 5 Screening form needed			
Attention concerns If yes, PST 5 Screening form needed			
Medical, mental health or health concerns, medications			
Previous Psychological and/or Social Developmental History			
Retentions-If yes, indicate grade level(s) of retention			
Intervention History			
IEP History			
504 Plan			
ELL			
Other concerns:			

Attach data if applicable

Next Step:

- _____ Complete a Student Progress Profile for the Appropriate Grade Level
 _____ Complete PST 2 Student Data Collection: Informal Parent Contact & Resource Consultations as parent contacts are made
 _____ Complete PST 3 Student Data Collection: Teacher Input & Observations

Teacher Signature

Date

Calhoun County Schools**Student Data Collection: Informal Parent Contact & Resource Consultations****PST 2 (Two parent contacts are required.)**

Student: _____ Grade: _____ School: _____

Parent/Guardian Consultation(s):

Meetings	Plan/Outcome from meeting: (Write a brief meeting summary.)
Meeting # _____	Date of Meeting: _____
Phone <input type="checkbox"/> In person <input type="checkbox"/> Email <input type="checkbox"/> Name of parent/guardian: _____ Teacher Signature: _____	_____ Vision, Hearing, Speech, Language, Behavior Screening is requested. Parent/guardian must sign a PST 5 Parental Notice/Consent for Screening and Intervention Activities.

Resource Consultations:

N/A

	Date(s)	Comments
Other Teachers		
Guidance Counselor/RTI Coach		
School Psychologist		
Behavior Analyst		
School Resource Officer		
Outside Agencies		

Calhoun County Schools Student Data Collection: Teacher Input & Observations

PST 3 (Complete #'s 1,7, 9, and 16 for Speech Referrals only. Indicate other areas as N/A for speech referrals.)

Student: _____ Grade: _____ School: _____
Low SES ρYes ρNo Served in ELL Program: ρYes ρNo

1) Academic Enablers:

Check appropriate description:	Always	Usually	Sometimes	Never
Attends class				
Is on time				
Comes to class prepared				
Completes class assignments				
Turns in homework				
Follows directions independently				
Appears to try hard/ Is motivated				

2) Academic Performance as compared to grade level expectancies: (check appropriate description)

Subject	Below Expectations	Meeting Expectations	Exceeding Expectations	Present Grade Average
Reading				
Language Arts				
Math				
Science				
Social Studies				
Other (specify):				

3) Indicate specific area(s) of concern in READING:

____ Phonemic Awareness ____ Decoding short words ____ Decoding multisyllabic words ____ Word Identification
____ Sight Words (automaticity of recall) ____ Reading Comprehension ____ Reading Fluency ____ Vocabulary Development
____ Other: _____
____ N/A

4) Indicate specific area(s) of concern in MATH:

____ Basic Math Facts (automaticity of recall) ____ Computation ____ Problem-Solving ____ Word Problems ____ Geometry
____ Measurement ____ Probability/Data ____ Analysis ____ Other: _____ ____ N/A

5) If academic performance is below expectations, what percentage of the class exhibits similar academic problems?

(Attach evidence i.e. STAR reports, i-Ready, Performance Matters Data, etc.)

☐ 5% or less ☐ 5%-20% ☐ 20-50% ☐ Over 50%

6) Classroom Interaction with Teacher:

Check appropriate description:	Always	Usually	Sometimes	Never
Demands Teacher Attention				
Appears inattentive, easily distracted				
Excessive concern with achievement				
Participates in class discussion/activities				
Responds appropriately to praise				
Responds appropriately to correction				
Impulsive—talks out—difficulty waiting turn				
Refuses to follow directions				
Makes inappropriate responses to conversation and questions				
Constantly seeks attention from adults				

7) Communication Observations:

Check appropriate description:	Always	Usually	Sometimes	Never
Misinterprets verbal questions and directions				
Poor understanding of vocabulary				
Difficulty following directions in sequence				
Difficulty expressing ideas				
Difficulty understanding student's speech				
Cannot imitate sounds correctly				
Speech not fluent, e.g. stuttering				
Vocal quality is hoarse, nasal, or has strident pitch				
Possible hearing problems				

8) Work Behavior:

Check appropriate description:	Always	Usually	Sometimes	Never
Reverses/confuses letters, words, numbers				
Frequently loses place when reading				
Poor gross motor control				
Poor fine motor control				
Difficulty staying on the line when writing				
Slow to react to and follow directions				
Performs inconsistently from day to day				
Difficulty working in whole group				
Difficulty working in small group				
Difficulty working independently				
Working one or more grade levels below in subject area : List area:_____				

9) Classroom Interaction with Peers:

Check appropriate description:	Always	Usually	Sometimes	Never
Interacts with peers inappropriately				
Disturbs others				
Leads others in inappropriate behaviors				
Joins others in inappropriate behaviors				
Low frustration tolerance				
Appears withdrawn				
Constantly seeks attention from other students				
Picks on others				
Is picked on by others				
Engages in destructive and/or aggressive behavior				
Poor judgment in interpersonal relations				

10) If behavior is always or usually a concern, what percentage of the class exhibits similar behavioral problems?

(Answer this item only if behavior is a concern.)

- ☐ 5% or less
 ☐ 5%-20%
 ☐ 20-50%
 ☐ Over 50%
 (Attach evidence)
- ☐ N/A

11) Indicate specific area(s) of concerns if BEHAVIORS are part of the problem:

____ Noncompliance ____ Motivation ____ Attention Span ____ Peer Relationships ____ Withdrawn
____ Mood Swings ____ Overactive ____ Verbally aggressive ____ Physically aggressive
____ # of current referrals ____ # of prior year referrals ____ # of ISS Days ____ # of OSS Days
____ Other: _____
____ N/A

12) Indicate other specific area(s) of concern if applicable:

____ Medical: (_____) ____ Attendance ____ Motor Skills ____ Listening Comprehension
____ Speech ____ Language ____ Social Skills ____ Anxiety ____ Vision ____ Hearing
____ Other: _____
____ N/A

13) Describe what you think is the student's biggest problem academically and/or behaviorally:

14) Why do you think this problem is occurring?

15) What strategies have been implemented in your classroom to help solve this problem?

16) What are the strengths of the student both academically and behaviorally?

17) Describe any recent trauma the student may have experienced (i.e. parents divorced, illness of student or family members, death of family member, etc.)

18) Does the student seek assistance from teachers, peers, others? ☐ Yes ☐ No

19) Is there evidence the student gets support from home to complete homework? ☐ Yes ☐ No

20) Are the student's achievement scores consistent with the student's grades ☐ Yes ☐ No

21) Has there been a significant change in the student's classroom performance within the last 6-12 months? ☐ Yes ☐ No

____ Date of PST 5 Parental Notice/Consent for Screening and Intervention Activities signed by the parent
____ Date completed PST 1, 2, 3, and 5 is given to the PST Chair (Include PST 4 if this is a Speech Referral)
(Include PST 7 if there are behavioral concerns).

Data attached: ____ i-READY ____ STAR READING ____ STAR MATH ____ Behavior Data
____ N/A if this is a speech referral or PK Student

Teacher Signature: _____ Date: _____

*PST 3 Teacher Input & Observations
Original and copy in Rtl folder
Copy to parent*

Calhoun County Schools
Problem Solving Team: Recommendation for Speech Screening
PST 4 (For Speech Concerns Only)

Student: _____ Grade: _____ School: _____

What is the presenting problem concern/description of problem according to the

Teacher: _____

Parent: _____

Student (if appropriate): _____

Is this student enrolled in any Exceptional Student Education? ☐ Yes ☐ No

If so, list programs: _____

Does this student have a history of health problems? ☐ Yes ☐ No

If so, list health history: _____

Does this student have a history of hearing problems? ☐ Yes ☐ No

If so, describe hearing problems: _____

Does this student have a history of learning problems? ☐ Yes ☐ No

If so, describe learning problems: _____

Has this student had previous speech therapy? ☐ Yes ☐ No

If so, when and where was therapy administered: _____

☐ **Screen for Vision, Hearing and Speech problems**

(Complete PST 5 screening consent/PST 6 screening report)

PST Chair: _____ Date: _____

Teacher: _____ Date: _____

PST 4 Problem Solving Team: Recommendation for Speech Screening
Original and copy in RtI folder
Copy to parent

Calhoun County Schools
Parental Notice/Consent for Screening and Intervention Activities
PST 5 Screening

Student: _____ Grade: _____ School: _____

Dear Parent/Guardian:

In an effort to maximize individual student success, our school has an intervention/Problem Solving team process in place. The purpose of the intervention/Problem Solving team is to:

- ♣ **Identify** the learning needs of students who are struggling with academics and may be at risk of school failure.
- ♣ **Provide** students with academic, emotional, behavioral, and social support needed to succeed in school by implementing general education interventions within the classroom setting.

The problem solving team may be comprised of teachers, administrators, reading coaches, Rtl coaches, and other district level staff such as the behavior analyst and school psychologist.

To assist your child in experiencing more school success, he/she has been referred to the school's Problem Solving Team to address his/her school performance. The team would like to gather more information by administering an individual screening. **The consent may include screening for vision, hearing, speech, language, behavior, cognitive or academic concerns.** Based on results of the screening, behavioral and/or academic interventions may be developed and implemented.

In order to conduct the necessary screenings and implement intervention activities, your consent for screening must be obtained. All information gathered will assist in educational planning and will be shared with you at your request.

Please check the appropriate box below, sign your name and date.

☐ YES, I give consent for my child to have an individual screening.

☐ NO, I do not give consent for my child to have an individual screening.

Comments: _____

Please return the form to _____ at _____

(Please contact this person if you have any questions or concerns.)

Parent Signature: _____ Date: _____

Calhoun County Schools
Problem Solving Team Screening Report
PST 6

Teacher's Name _____

Student: _____ DOB: _____ Grade: _____ School: _____

Date of request for screening _____ Reason for screening: _____

Instrument Used: _____

Date: _____

RIGHT _____
 500 HZ 1000HZ 2000 HZ 4000 HZ
 Audiometric screening at 25db

LEFT _____
 500 HZ 1000HZ 2000 HZ 4000 HZ
 Audiometric screening at 25db

Passed: _____ Failed: _____

Passed: _____ Failed: _____

Further Evaluation Required: ____Yes ____No

Comments: _____

Signature of Person Responsible/Position: _____

VISION

Instrument Used: _____ Date: _____
 RIGHT _____ Passed: _____ Failed: _____ LEFT _____ Passed: _____ Failed: _____

BOTH EYES _____ Passed: _____ Failed: _____

- Does the student wear glasses/contact lenses? ____Yes ____No
- Did the student wear glasses/contact lenses for the screening? ____Yes ____No

Further Evaluation Required: ____Yes ____No

Comments: _____

Signature of Person Responsible/Position: _____

SPEECH o N/A

Instrument Used: _____ Date: _____ Articulation: _____
 Fluency: _____ Phonological: _____ Voice: _____
 Connected/Conversational Speech : _____ Further Evaluation Required: ____Yes ____No
 Comments: _____

Signature of Person Responsible/Position: _____

LANGUAGE o N/A

Instrument Used: _____ Date: _____

Total Score		+ At or Above Criterion
Criterion Score		- Below Criterion

Conversational Speech: _____

Passed: _____ Failed: _____ If failed, implement interventions.

Comments: _____

Signature of Person Responsible/Position: _____

BEHAVIOR o N/A

Instrument Used: _____ Date: _____ Attach behavior screening checklists.

Passed: _____ Failed: _____ If failed, implement interventions.

**** If interventions are recommended, the teacher must complete PST 7.**

COGNITIVE o N/A

Instrument Used: _____ Date: _____

Standard Score: _____ This student is a candidate for an InD referral.
 Verbal _____ This student is not a candidate for an InD referral. Implement interventions.
 Nonverbal _____ This student is a candidate for a Gifted referral.
 IQ composite _____ This student is not a candidate for a Gifted referral.

Comments: _____

Signature of Person Responsible/Position: _____

Original and copy in Rtl folder - Copy to parent

Calhoun County Schools

Problem Solving Team: Analysis of Problem

Teacher Input for Student Behaviors

PST 7 (mandatory for any student exhibiting behavior concerns)

Problem Solving Team Process - Behavior

Name: _____ DOB: _____ Grade: _____ Date: _____

Teacher: _____

Check all the behavior(s) below that appear to be interfering with the student's performance on a regular basis:

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Frequently argues with peers <input type="checkbox"/> Frequently argues with staff <input type="checkbox"/> Fails to finish things he/she begins <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Poor social skills <input type="checkbox"/> Cannot sit still, restless, overly active for age <input type="checkbox"/> Clings to adult, very dependent <input type="checkbox"/> Cries often <input type="checkbox"/> Bullies others <input type="checkbox"/> Physically aggressive to others <input type="checkbox"/> Acts without thinking <input type="checkbox"/> Demands lots of attention from staff <input type="checkbox"/> Seeks attention from peers <input type="checkbox"/> Destroys property <input type="checkbox"/> Lacks organization, can't manage materials <input type="checkbox"/> Seems fearful <input type="checkbox"/> Would rather be alone than with others <input type="checkbox"/> Lying, cheating <input type="checkbox"/> Steals <input type="checkbox"/> Difficulty making/keeping friends <input type="checkbox"/> Difficulty with transitions | <ul style="list-style-type: none"> <input type="checkbox"/> Often appears nervous or tense <input type="checkbox"/> Uses obscene language <input type="checkbox"/> Sudden changes in mood, feelings <input type="checkbox"/> Difficulty following directions <input type="checkbox"/> Frequently avoids tasks <input type="checkbox"/> Refuses to talk <input type="checkbox"/> Does not show guilt after misbehaving <input type="checkbox"/> Consequences have little effect <input type="checkbox"/> Breaks school/classroom rules frequently <input type="checkbox"/> Bothers peers while they are working <input type="checkbox"/> Frequently makes careless mistakes on tasks <input type="checkbox"/> Avoids groups/peers <input type="checkbox"/> Repeats actions over and over <input type="checkbox"/> Picks nose, skin, or other body part |
|---|---|

Prioritize Top 2 Concerns Below:

1. _____
2. _____

From the list below, indicate antecedents (what happens before the behavior), setting (where behavior occurs) and consequences (what happens after the behavior).

Antecedents			Setting/Concurrent Event			Consequences		
#1	#2	Behavior	#1	#2	Behavior	#1	#2	Behavior
<input type="checkbox"/>	<input type="checkbox"/>	Lack of social attention	<input type="checkbox"/>	<input type="checkbox"/>	Independent seat work	<input type="checkbox"/>	<input type="checkbox"/>	Behavior ignored
<input type="checkbox"/>	<input type="checkbox"/>	Demand/Request from	<input type="checkbox"/>	<input type="checkbox"/>	Group instructions	<input type="checkbox"/>	<input type="checkbox"/>	Teacher attention
<input type="checkbox"/>	<input type="checkbox"/>	Difficult tasks – does not understand	<input type="checkbox"/>	<input type="checkbox"/>	Crowded seating (lunch, recess)	<input type="checkbox"/>	<input type="checkbox"/>	Peer attention
<input type="checkbox"/>	<input type="checkbox"/>	Transition (task)	<input type="checkbox"/>	<input type="checkbox"/>	Unstructured activity	<input type="checkbox"/>	<input type="checkbox"/>	Reprimand/warning
<input type="checkbox"/>	<input type="checkbox"/>	Transition (setting)	<input type="checkbox"/>	<input type="checkbox"/>	Unstructured setting	<input type="checkbox"/>	<input type="checkbox"/>	Teacher talks to student
<input type="checkbox"/>	<input type="checkbox"/>	Interruption in routine	<input type="checkbox"/>	<input type="checkbox"/>	Specific subject/task	<input type="checkbox"/>	<input type="checkbox"/>	Other staff talks to
<input type="checkbox"/>	<input type="checkbox"/>	Negative peer interaction	<input type="checkbox"/>	<input type="checkbox"/>	Transitional times	<input type="checkbox"/>	<input type="checkbox"/>	Time-Out
<input type="checkbox"/>	<input type="checkbox"/>	Classroom is noisy	<input type="checkbox"/>	<input type="checkbox"/>	En-route to/from school	<input type="checkbox"/>	<input type="checkbox"/>	Loss of privilege
<input type="checkbox"/>	<input type="checkbox"/>	Student is off-task, restless	<input type="checkbox"/>	<input type="checkbox"/>	Special Area (art, P.E.music)	<input type="checkbox"/>	<input type="checkbox"/>	Penalty imposed
<input type="checkbox"/>	<input type="checkbox"/>	Consequences imposed	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Removed from class
<input type="checkbox"/>	<input type="checkbox"/>	Other				<input type="checkbox"/>	<input type="checkbox"/>	Sent to office
						<input type="checkbox"/>	<input type="checkbox"/>	In-School Suspension
						<input type="checkbox"/>	<input type="checkbox"/>	Out-of-school suspension
						<input type="checkbox"/>	<input type="checkbox"/>	Contact Parents

PST 7 (page 2) Behavioral Observation Teacher Form (one form for each targeted behavior)

Student Name: _____

When does the behavior occur the most?
(Time?)

- ☐ Morning
- ☐ Afternoon
- ☐ Before/after school
- ☐ Lunch/recess

Where does the behavior occur the most?

- ☐ Regular classroom
- ☐ Cafeteria
- ☐ Hallways
- ☐ Other _____

How often does the behavior typically

- ☐ Times per day _____
- ☐ Times per week _____
- ☐ Random _____

occur?

Other Events of conditions occurring right before this behavior:

- ☐ Teacher request
- ☐ A consequence has been imposed
- ☐ Unexpected schedule change
- ☐ Other _____

Who is present when the problem behavior is most likely to occur:

- ☐ Teacher
- ☐ Peers
- ☐ Paraprofessional/TA
- ☐ Other _____

Teachers: This questionnaire is designed to identify those situations where a student is likely to behave in specific ways. From this information, more informed decisions can be made about the selections of appropriate replacement behaviors. Select one behavior of specific interest. Be specific about the behavior. For example “is aggressive” is not as good a description as “hits other people.” Once you have specified the behavior to be rated, read each question carefully and circle the one number that *best describes your* observations of this behavior.

What is the specific behavior you are rating below?

Questions	Never 0	Almost Never 1	Seldom 2	Half the Time 3	Usually 4	Almost Always 5	Always 6
1. Would the behavior occur continuously if this student were left alone for long periods of time?	0	1	2	3	4	5	6
2. Does the behavior occur following a request to perform a difficult task?	0	1	2	3	4	5	6
3. Does the behavior seem to occur in response to your talking to other students in the room?	0	1	2	3	4	5	6
4. Does the behavior ever occur to get a toy, food, or an activity that this person has been told he/she can't have?	0	1	2	3	4	5	6
5. Would the behavior occur repeatedly, in the same way, for long periods of time if the student was alone? (e.g. rocking back and forth for over an hour.)	0	1	2	3	4	5	6
6. Does the behavior occur when any request is made of this student?	0	1	2	3	4	5	6
7. Does the behavior occur whenever you stop attending to this student?	0	1	2	3	4	5	6

Questions	Never 0	Almost Never 1	Seldom 2	Half the Time 3	Usually 4	Almost Always 5	Always 6
8. Does the behavior occur when you take away a favorite food, toy or activity?	0	1	2	3	4	5	6
9. Does it appear to you that the student enjoys doing the behavior?	0	1	2	3	4	5	6
10. Does this student seem to do the behavior to upset or annoy you when you are trying to get him/her to do what you ask?	0	1	2	3	4	5	6
11. Does this student seem to do the behavior to upset or annoy you when you are not paying attention to him/her? (e.g. you are in another room or interacting with another person)	0	1	2	3	4	5	6
12. Does the behavior stop occurring shortly after you give the student food, toy, or requested activity?	0	1	2	3	4	5	6
13. When the behavior is occurring does this student seem calm and unaware of anything else going on around her/him?	0	1	2	3	4	5	6
14. Does the behavior stop occurring shortly after (one to five minutes) you stop working with or making demands of this student?	0	1	2	3	4	5	6
15. Does this student seem to initiate the behavior to get you to spend some time with her/him?	0	1	2	3	4	5	6
16. Does the behavior seem to occur when this student has been told that he/she can't do something he/she had wanted to do?	0	1	2	3	4	5	6

Directions: Transfer the numeric answer for each question to the blanks above. Scores are organized into columns by type of motivation. Add the total score to get the highest score.

	Sensory	Escape	Attention	Tangible
	1.	2.	3.	4.
	5.	6.	7.	8.
	9.	10.	11.	12.
	13.	14.	15.	16.
Total Score =				

Calhoun County Schools
Problem Solving Team: Team Intervention Development & Implementation Plan
PST 8

Original and copy in Rtl folder
 Copy to parent

Student: _____ Grade: _____ Meeting Date: _____
 Teacher: _____ School: _____

Intervention # _____ Anticipated Start Date: _____ Anticipated End Date: _____
 (average time 4 -6 weeks later)

Intervention #2 Additional Interventions require an increase in frequency, duration and reduction in group size.

Area of Concern: ☐ Reading ☐ Math ☐ Language Arts ☐ Behavior ☐ _____

Specific Academic Skill or Targeted Behavior: _____

Attach applicable Appendix D form – “Guide to Defining the Problem”

Name of Intervention Program (if applicable): _____

Researched-based strategy: _____

Setting of intervention: ☐ Classroom ☐ Other (specify): _____

Group Size: ☐ Individual: ☐ 2-3 ☐ 4-8 ☐ More than 8 but not whole class

Frequency: ☐ One X/Wk ☐ Two X/Wk ☐ Three X/Wk ☐ Four X/Wk ☐ Daily

Duration: ☐ 15 min ☐ 20 min ☐ 30 min ☐ 45 min ☐ 60 min ☐ Other: _____

Intervention Provider: ☐ GenEd ☐ ESE ☐ Counselor ☐ Volunteer ☐ Paraprofessional
☐ Other (specify role) _____

Define Peer Group #1 _____

Define Peer Group #2 _____

Team Members present for Intervention Development:

PST Chair: _____ Teacher: _____

Teacher: _____ Other: _____

Parent: _____ Other: _____

Progress Monitoring Data for Intervention # _____

(include Data Worksheet, graphs, etc.)

Name of assessment used to determine baseline/data points: _____

Date: _____ Baseline data point: _____ Projected benchmark: _____

Data Point	Date	Student Data Point	Class Data Point	School Data Point	District Data Point	State Data Point	Peer Group #1	Peer Group #2
BASELINE								
wk1								
wk2								
wk3								
wk4								
wk5								
wk6								

All data points are required as indicated above. **IF INCOMPLETE, this form will be returned to the teacher.**

Calhoun County Schools
Problem Solving Team: Response to Team Intervention Follow-up Meeting
PST 9

Student: _____ Grade: _____ Meeting Date: _____

Teacher: _____ School: _____

Follow-up Meeting for Intervention # _____ Subject: _____

The intervention was researched-based? ☐ Yes ☐ No

Since the time the targeted intervention was started, has the problem ☐ decreased ☐ stayed the same ☐ increased

Student's current level of support: ☐ Tier One ☐ Tier Two ☐ Tier Three, if applicable

Was attendance during the intervention sessions an issue? ☐ Yes ☐ No

If yes, how many days has student been absent since implementing the intervention? _____

Since the intervention was implemented, describe the student's current performance: _____

Team decision(s):

- ☐ Continue intervention as previously written on PST 8 dated: _____ Follow-up meeting scheduled for _____
- ☐ Modify the intervention as indicated on PST 8 dated: _____ Follow-up meeting scheduled for : _____
- ☐ Develop a new intervention using PST 8 targeting problem area.
- ☐ Behavior Analyst will complete classroom observation
- ☐ Refer to Alternative/Drop Out Prevention Program: _____
- ☐ Consider eligibility for 504 Plan
- ☐ Consider referral for a formal evaluation(s).
- ☐ Refer for counseling
- ☐ Refer to community agency

End of Year Review:

- ☐ Re-Visit Intervention at beginning of next school year
- ☐ Student is making progress and intervention will be closed out.

☐ Other: _____

Team Member Signatures who were present at meeting:

PST Chair: _____ Principal: _____

Teacher: _____ Other: _____

Parent: _____ Other: _____

Calhoun County Schools
Exceptional Student Education
Parental Notice/Consent for Initial Evaluation
PST 10

Person/Entity Requesting
Evaluation:

- ☐ Parent/Guardian
- ☐ School Team
- ☐ Other _____

Student: _____ ID: _____ Date: _____

Grade: _____ DOB: _____ Teacher: _____ School: _____

Dear Parent/Guardian:

In order to develop an appropriate educational program for your child, additional information is needed. A comprehensive evaluation is recommended to assist the problem solving team in meeting the educational needs of your child. The evaluation is proposed based on your child's educational performance and review of any previous MTSS/RtI or evaluation information, as well as observations and conferences or because you have requested that an evaluation for ESE services be conducted.

The following educational options have been considered or used with your child but determined to be insufficient in meeting his/her educational needs and have been rejected as the primary method of assisting your child:

- ☐ Academic Interventions
- ☐ Behavioral Interventions
- ☐ N/A (This evaluation is being requested by the parent/guardian.)
- ☐ N/A (This evaluation is being requested to determine eligibility for Speech Therapy.)
- ☐ N/A (This evaluation is being requested to determine eligibility for Gifted.)

We are requesting your consent to use your child's existing MTSS/RtI data and to conduct a comprehensive evaluation to include:

- ☐ Academic Achievement Assessment
- ☐ Adaptive Behavior Assessment
- ☐ Assistive Technology Evaluation
- ☐ Developmental Inventory/Assessments
- ☐ Functional Behavioral Assessment
- ☐ Gifted Characteristics Checklist Assessment
- ☐ Hearing Evaluation
- ☐ Individual Intellectual Evaluation
- ☐ Language Evaluation
- ☐ Learning Abilities Evaluation
- ☐ Occupational Therapy Evaluation
- ☐ Physical Therapy Evaluation
- ☐ Medical Evaluation
- ☐ Speech Evaluation
- ☐ Social and Developmental History
- ☐ Vision Evaluation
- ☐ Other: _____

Gifted Referral Only

- ☐ Academic Achievement Assessment
- ☐ Gifted Characteristics Checklist Assessment
- ☐ Individual Intellectual Evaluation

Speech Referral Only

- ☐ Speech Evaluation

PARENT CONSENT FOR INITIAL ESE EVALUATION

Once the evaluation is completed, you will be advised of the results. Please sign and return this document to your child's school. If you have questions, please contact _____ at _____.

- ☐ YES, I give consent for an evaluation and understand my rights as explained in the attached notice of Procedural Safeguards.
- ☐ NO, I do not give consent for an evaluation for the following reasons: _____

Parent Signature

Date

As parent(s)/guardian(s) of a child with a disability, you have certain protections under the attached Notice of Procedural Safeguards. For a gifted student, you have protections under the Procedural Safeguards under Rule 6A-6.03313, FAC. Further explanation of rights and copies may be obtained from the ESE Director or the Guidance Counselor at your child's school.

OFFICE USE-RECORDS OF CONTACT ATTEMPTS:

- ☐ N/A (signed at parent conference)

Date: _____ Type: _____ Results: _____ By: _____

PST 10 Parental Notice/Consent for Evaluation
Original and copy in RtI folder; Copy to parent

Calhoun County Schools
Problem Solving Team: Referral for Formal Evaluation
PST 11

For ESE Office Use Only:
Date Rtl Referral Received _____

Date Referred to Evaluation Specialist _____
ESE Director/Designee Signature _____
Low SES Yes ___ No ___
ELL Student Yes ___ No ___

Student: _____ **ID:** _____ **Date:** _____

Grade: _____ **DOB:** _____ **Teacher:** _____ **School:** _____

Required Determination for Referral. Student cannot be referred for an evaluation unless at least one of the following determinations is made and documented here (check all that apply):

- ____ General education intervention procedures have been implemented as required and the data indicate that the student may be a student with a disability who needs special education and related services.
____ An evaluation has been requested by the student's parent(s) and the general education intervention procedures will be completed concurrently with the evaluation but prior to a determination of the student's eligibility for special education and related services; or
____ The nature or severity of the student's area(s) of concern make the general education intervention procedures inappropriate to address the immediate needs of the student.

Reasons for referral:

- ☐ Poor Academic Achievement in
- ☐ Reading
- ☐ Math
- ☐ Written Language
- ☐ Other _____
- ☐ Speech Concerns
- ☐ Language Concerns
- ☐ Fine Motor Concerns
- ☐ Gross Motor Concerns
- ☐ Classroom Behavior Concerns
- ☐ Emotional Concerns
- ☐ Vision Concerns
- ☐ Hearing Concerns
- ☐ Intellectual Concerns
- ☐ Gifted Characteristics noted by teacher
- ☐ Physical/Health Concerns
- ☐ Parent Request

Team decision(s): Any referral for evaluation(s) listed below requires the PST 10 Parental Notice/Consent for Evaluation Form to be signed.

- ☐ Refer for Formal Psychological Evaluation
- ☐ Refer for Health Evaluation
- ☐ Refer for Speech Evaluation
- ☐ Refer for Language Evaluation
- ☐ Refer for Vision Evaluation
- ☐ Refer for Hearing Evaluation
- ☐ Refer for Intervention Data Analysis Evaluation
- ☐ Refer for Functional Behavior Assessment (FBA)
- ☐ Refer for Occupational Therapy Evaluation
- ☐ Refer for Physical Therapy Evaluation (*PT prescription from physician is needed for PT evaluation*)
- ☐ Refer for 504 Accommodation Plan Consideration
- ☐ Other: _____

- ☐ **Complete Social/Developmental History ESE #7** ☐ N/A
(Form ESE 7 Social/Developmental History is required for all referrals for formal evaluations except Gifted and speech referrals.)
- ☐ **Complete ESE 12C for Students with Health Impairments** ☐ N/A
(Form ESE 12C must be completed and signed by the student's physician if student has health concerns.)

Date of Consent for Initial Evaluation on PST 10:** _____ ☐ N/A

Date of ESE#19 if the student is already enrolled in an ESE program: _____ ☐ N/A

****Immediately send the signed PST 10 evaluation consent form and completed RTI folder to the ESE Director when the parent/guardian has given consent for evaluation. The 60 day evaluation timeline begins when the district receives the signed Parental Notice/Consent for Evaluation Form.**

Team Members Present at time of referral:

PST Chair: _____ **Principal/Designee:** _____

Teacher: _____ **Teacher:** _____

Other/Title: _____ **Other/Title:** _____

**Calhoun County School Board
Exceptional Student Education
SOCIAL/DEVELOPMENTAL HISTORY INTERVIEW**

I. Identifying Information

Student's Name: _____ Student No: _____ Date of Birth: _____
Student's Race: _____ Sex ☐ Male ☐ Female Current Age: _____
Student's Home Address _____
Home Telephone Number: _____ Emergency Phone Number: _____
Father's Name: _____ Father's Age: _____ Occupation: _____
Last Grade Completed in School: _____ Legal Guardian: ☐ Yes ☐ No
Mother's Name: _____ Mother's Age: _____ Occupation: _____
Last Grade Completed in School: _____ Legal Guardian: ☐ Yes ☐ No
With Whom does Student Live? _____
Other Family Members: Name Age Relationship

II. Medical Information

Name of physician: _____ Date of last examination: _____
Medications Student Takes: _____
Description of student's general health: _____

III. Pregnancy

Check one: ☐ Normal full term ☐ Premature ☐ Overdue

Describe any illnesses of mother during pregnancy: _____

Medications of the mother during pregnancy: Prescribed Medications: _____
 Smoking (How many packs): _____
 Alcohol (How much per day): _____
 Non-Prescribed Medications: _____
Place of birth: _____ Baby's Birth Weight: _____
Any complications or difficulties about the birth? _____
Did the baby have any illnesses immediately after birth? _____

IV. Developmental History

Age sat up: _____ Age walked: _____ First Word: _____
When did toilet training begin? _____ Age toilet trained: _____
Any problems with toilet training? _____
Any problems learning to walk, or talk? _____
Attended pre-kindergarten program? ☐ Yes ☐ No If Yes, Where _____
Attended Kindergarten? ☐ Yes ☐ No If Yes, Where? _____
Attended other program? ☐ Yes ☐ No If Yes, Where? _____
Grades retained _____

V. Behavioral Information

Social/Developmental History Interview Page 2 of 3

Does the child exhibit any problems in the following areas? If so, please describe:

- | | |
|--|--|
| <input type="checkbox"/> Sleeping:_____ | <input type="checkbox"/> Asthma:_____ |
| <input type="checkbox"/> Hearing:_____ | <input type="checkbox"/> Headaches:_____ |
| <input type="checkbox"/> Speech:_____ | <input type="checkbox"/> Nail Biting:_____ |
| <input type="checkbox"/> Vision:_____ | <input type="checkbox"/> Worries:_____ |
| <input type="checkbox"/> Timidity:_____ | <input type="checkbox"/> Eating Concerns:_____ |
| <input type="checkbox"/> Bedwetting/Soiling:_____ | <input type="checkbox"/> Seizures:_____ |
| <input type="checkbox"/> Cruelty:_____ | <input type="checkbox"/> Nightmares:_____ |
| <input type="checkbox"/> Temper Tantrums:_____ | <input type="checkbox"/> Silent Periods:_____ |
| <input type="checkbox"/> High Activity Level:_____ | <input type="checkbox"/> Physical Aggression:_____ |
| <input type="checkbox"/> Prone to Accidents:_____ | <input type="checkbox"/> Other:_____ |
| <input type="checkbox"/> Inability to have friends:_____ | |

How is the child's relationship to the parents? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What types of discipline are most effective with the child?_____

VI. Family and Relatives

Have any of the student's relatives had any of the characteristics below?

Emotional Problems_____	Relationship_____
Academic Difficulties_____	Relationship_____
Medical Problems_____	Relationship_____
Physical Disabilities_____	Relationship_____

VII. Parent/Child Interaction

What circumstances commonly cause conflict between the parent and student?_____

How do the parents see the student's problem? _____

What is the parent's view of when and how the problem began? _____

VIII. The examiner ascertains if any of the following behaviors are evident and places a check in Yes or No boxes.

A. Social interaction as evidenced by the delay, difference, absence, or abnormality in the ability to relate to people and environment. These may include one or more of the following behavioral indicators:

- | | |
|-----------|--|
| Y___ N___ | Limited joint attention and limited use of facial expressions directed toward others |
| Y___ N___ | Does not show or bring things to others to indicate an interest in the activity |
| Y___ N___ | Demonstrates difficulties in relating to people, objects, and events |
| Y___ N___ | A gross impairment in ability to make and keep friends |
| Y___ N___ | Significant vulnerability and safety issues due to social naiveté |

Y___ N___ May appear to prefer isolated or solitary activities

Y___ N___ Misinterprets others' behaviors and social cues

B. Verbal and/or nonverbal language or social communication skills as evidenced by one or more behavioral indicators:

Y___ N___ Showing a lack of spontaneous imitations or lack of varied imaginative play

Y___ N___ Absence or delay of spoken language

Y___ N___ Limited understanding and use of nonverbal communication skills such as gestures, facial expressions, or voice tone

Y___ N___ Odd production of speech including intonation, volume, rhythm, or rate

Y___ N___ Repetitive or idiosyncratic language or inability to initiate or maintain a conversation when speech is present

Y___ N___ Not using a finger to point or request

C. Repetitive and/or stereotyped patterns of behavior, interests, or activities as evidenced by one or more behavioral indicators:

Y___ N___ Insistence on following rules or rituals

Y___ N___ Demonstrating distress or resistance to changes in activity

Y___ N___ Repetitive hand or body mannerisms

Y___ N___ Lack of true imaginative play versus reenactment

Y___ N___ Over-reaction or under-reaction to sensory stimuli

Y___ N___ Rigid or rule-bound thinking

Y___ N___ Encompassing preoccupation with one or more stereotyped or restricted patterns of interest that is abnormal either in intensity or focus

IX. Additional Comments

Respondent's Name _____ Date _____

Interviewer Name _____ Title _____ Date _____

ESE #7 (Revised 8/2010; Printed 8/2011)
Calhoun County Schools
Problem Solving Team Meeting Invitation

Copy – ESE School
Copy – ESE Office
Copy – Parent/Adult

Date: _____

To the Parent/Guardian of: _____

School: _____

Grade: _____

The Problem Solving Team is a committee of people at our school who meets on a regular basis to help general education teachers find new or different ways to help specific students improve academic or behavior skills. Your child has been referred to the team by his/her classroom teacher.

Meetings are held throughout the school year to discuss appropriate interventions to help your child succeed academically or behaviorally in the general education setting. Meetings are also held to discuss your child's progress and make further recommendations as needed.

You are invited to attend a meeting scheduled for your child

at _____ **on** _____ **at** _____
School Date Time

This meeting will be:

- ____ An initial Problem Solving Team meeting
____ A follow-up Problem Solving Team meeting
____ Per Parent Request

If you have any questions or need more information please do not hesitate to contact

_____ at _____.

Please check the appropriate response, sign, and return to the contact person prior to the scheduled meeting.

- ____ Yes, I will attend the meeting
____ I wish to attend but on another date and time. Please contact me at _____ to reschedule the meeting.
____ I am unable to attend, but do give my permission for the meeting to proceed without me.
____ I wish to participate in this meeting via phone conference.
Please contact me at this phone # _____ for the scheduled meeting.

Parent/Guardian Signature

Date

Telephone number

Parent contact attempts:

Date: _____ Type: _____ Results: _____ By: _____

Original and copy in Rtl folder; Copy to parent

Calhoun County Schools Problem Solving Team Meeting Summary

Student: _____ **Grade:** _____ **Date:** _____

Teacher: _____ **School:** _____

Please record summary of meeting below:

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Parent	PST Chair
Student	Guidance Counselor
Teacher	Principal
Teacher	District Rtl Coordinator
Other	Other

- o Parent was invited to PST meeting via phone. A separate written invitation was not completed.

PST Meeting Summary
Copy to parent

Original and copy in Rtl folder

APPENDIX A

Sample Form
School Vision Screening
Parent/Guardian Notification

(School name)

Dear Parent or Guardian:

When your child was screened for vision at school, he/she had some trouble reading the charts. Your child's health and vision are important to us. These results may or may not mean there is a problem; therefore it is recommended that your child's eyes be examined by an eye care professional. It is requested that you take this form to your child's eye exam along with the enclosed "Report of Eye Examination to the School" form. Return the completed "Report of Eye Examination to the School" form to the school as soon as possible. Thank you for your cooperation.

Your child _____ in grade _____

Received a vision screening at school on _____. The following results were obtained:

Observations: _____

Vision Test	Without Lenses	With Lenses
Distance Acuity	Right Eye 20/ _____	Right Eye 20/ _____
	Left Eye 20/ _____	Left Eye 20/ _____
Near Acuity	Right Eye 20/ _____	Right Eye 20/ _____
	Left Eye 20/ _____	Left Eye 20/ _____
Plus Lens (+ 2.25):	Right Eye 20/ _____	Right Eye 20/ _____
	Left Eye 20/ _____	Left Eye 20/ _____

(Signature of school health professional)

(Date)

APPENDIX B

Sample Form **Report of Professional Eye Examination to the School** (Return completed form to school)

Student name _____ DOB _____

Grade _____ Date of Examination _____

Visual Acuity **Distance** Without correction: R _____ L _____

With Correction: R _____ L _____

Visual Acuity **Near** Without correction: R _____ L _____

With Correction: R _____ L _____

Peripheral vision, if fields are restricted, indicate degree and location: _____

Diagnosis: _____

Plan: ☐ No treatment at this time ☐ Eyeglasses ☐ Contact Lenses ☐ Patch

☐ Other _____

Please indicate when or under what conditions corrective lenses/patch should be worn:

Requirements: _____ Correction not required

_____ Correction prescribed

_____ Glasses

_____ Contact Lenses

Corrected Visual Acuity: R 20/ _____ L 20/ _____

Frequency of Classroom Use:

_____ Wear at all times

_____ Wear for distance only

_____ Wear for reading tasks only

_____ Other (specify) _____

Physical Education: (Note: Only polycarbonate lenses are acceptable for wear during physical education)

_____ Wear for physical education

_____ Remove for physical education

Signature/Title _____ **Telephone #** _____

APPENDIX C

Date: _____

Dear _____:

As we discussed, your child has recently failed hearing screenings, which may indicate your child is experiencing a hearing loss. Research suggests that even the mildest hearing loss can cause learning problems and affect academic performance. Therefore, your child's hearing should be evaluated by your child's physician as soon as possible.

If you have questions, please contact _____ at _____.

Thank you,

Sincerely,

(Speech-Language Pathologist or School Nurse)

APPENDIX D

Guide to Defining the Problem

Problem Solving Team Process

READING

Student: _____

How is reading assessed in the teacher's class (i.e. assessment instrument, skills measured, how often)? _____

What is the student's reading level? _____

What is the expected reading level at this point in the school year? _____

Check areas that the student has NOT mastered for his/her current grade level

Early Literacy Skills/Phonological Awareness:

- o Book/print awareness (*parts of book, directionality, follow along when listening to text read aloud, etc.*)
- o Recognize/produce rhyming words
- o Syllables – *count, blend, segment, delete syllables in compound words*
- o Match/identify beginning sounds in words
- o Match/identify ending sounds in words
- o Blend sounds of one-syllable word (*e.g. what word am I saying? /r/ /u/ /n/*)
- o Segment sounds of one-syllable word (*e.g. how many sounds do you hear in man?*)
- o Manipulate sounds – *delete, add, or substitute individual sounds to produce a new word*

Decoding/Word Recognition:

- o Recognize and name upper and lower case letters of the alphabet
- o Recognize letter-sound association
- o Use letter-sound knowledge to decode one-syllable words when reading
- o Use structural analysis (e.g. syllables, prefixes, suffixes, root words) to decode multi-syllable words when reading.
- o Use context clues to decode
- o Self-monitoring decoding using multiple decoding strategies
- o Recognize high frequency sight words at grade-appropriate level
- o Grade appropriate development of oral vocabulary
- o Grade appropriate development of reading vocabulary and word meaning

Fluency:

- o Reads aloud grade-level text accurately
- o Uses appropriate phrasing, smoothness, and pace when reading text

Comprehension:

- o Retell (beginning, middle, end, characters, details, etc.)
- o Answer who, what, when, where, how questions
- o Predict what may happen next in stories
- o Summarize main idea
- o Cause and effect, problem/resolution
- o Draw conclusions
- o Make inferences
- o Use self-monitoring strategies for comprehension (e.g. reread, adjust reading speed, paraphrase, retell, etc.)
- o Understanding complex text

APPENDIX D

Guide to Defining the Problem

Problem Solving Team Process

Math

Student: _____

Check areas that the student has NOT mastered for his/her current grade level

Number Sense:

- o Rote Count
- o One-to-one correspondence
- o Read numbers
- o Write numbers
- o Representing numbers in multiple ways
- o Comparing and ordering numbers
- o Place value
- o Fractions

Computation:

- o Equality
- o Basic addition/subtraction/multiplication/division facts
- o Multi-digit addition/subtraction/multiplication/division facts
- o Estimation

Problem Solving:

- o Understanding of operation to be used
- o Understanding of steps involved in multi-step problem
- o Correctly computes solution using reasoning
- o Uses multiple strategies, including the use of a calculator
- o Reading to solve word problems

Other:

- o Geometry (2 dimensional/3 dimensional)
- o Measurement (linear/mass/capacity/area/perimeter/time/temperature/money)
- o Probability/data analysis
- o Algebra (patterning/properties)
- o Other: _____

APPENDIX D

Guide to Defining the Problem *Problem Solving Team Process* WRITING

Student: _____

Which area(s) has the student NOT mastered for his/her current grade level?

Conventions:

- o Spelling
- o Punctuation
- o Capitalization
- o Grammar
- o Understands directionality of writing (e.g., left-to-right, top-to-bottom)

Content

- o Orally expresses ideas in organized and coherent manner
- o Uses drawings and/or letter strings to express ideas
- o Idea development/elaboration
- o Organization/sequence
- o Focus/remains on topic
- o Vocabulary/word usage is grade appropriate
- o Sentence structure (varied length, complete sentences, sentence fluency, etc.)
- o Other area(s) of concern: _____

APPENDIX D

Guide to Defining the Problem - *Problem Solving Team Process* Fine Motor

Student: _____

Personal Care Skills:

- o Student shows significant difficulties with *feeding self or managing meal process* as compared to peers
- o Student shows significant difficulties with *hygiene skills* such as toileting or washing hands as compared to peers
- o Student shows significant difficulties with *managing clothing* (putting on/off and fasteners) as compared to peers
- o Student has much difficulty with *organization of materials* (papers, notebooks, book bag, art materials, computer) *or organization of self* (assignments, managing schedule, following routine, transitions, set-up/clean-up, completing homework, being on time, etc.)

Student Role/Interaction Skills:

- o Student has significant difficulties *managing fine motor skills and manipulatives* in class (sharpening pencil, glue, coloring, scissors, writing utensils, math materials)
- o Student shows a *poor grasp* on writing utensils
- o Student shows poor *finger/hand strength* to open materials/packages age appropriately or use classroom materials.

Play:

- o Student has difficulty *using toys/items* for intended purpose
- o Student has difficulty *engaging with other children* to play
- o Student has *small repertoire of play skills*

Graphic Communication:

- o Student shows significant difficulties with *handwriting* as compared to peers:
 - o Too little or too much pressure on paper
 - o Switches writing hand
 - o Poor spacing, alignment or letter formation
 - o Messy work, erases or writes over a lot
 - o Poor written organization/spatial planning
- o Student is *slow with handwriting* speed and has difficulty completing assignments as compared to peers
- o Student has difficulty with *keyboarding* as compared to peers.

Visual Perceptual/Ocular Motor:

- o Student has difficulty *copying* from the board or near source in timely manner
- o Displays frequent *reversals* in writing work for his age
- o Student has difficulty with *reading, location information on a page*, or word search
- o Student has much trouble *sequencing and following a visual model* (block designs, crafts, parquetry, etc.)

Sensory/Work Behaviors:

Student shows significant aversion to *handling various textures*

- o Student shows many *self-stimulatory behaviors* or is very ritualistic
- o Student shows great fear of *movement activities/playground equipment*
- o Student shows significant *aversion to loud noises, visual stimulation*
- o Student has much difficulty *getting along with other children*
- o Student shows much difficulty with *transitions or routines*

APPENDIX D

Guide to Defining the Problem -*Problem Solving Team Process* Speech/Language

Student: _____

Articulation/Pronunciation:

- o Student omits, substitutes, or distorts sounds in words
- o When speaking, student's speech is unintelligible
- o Other

Voice/Vocal Quality:

- o Student has unusual vocal quality (hoarse, harsh, breathy, nasal, high/low pitch)
- o Student has difficulty using appropriate intensity/loudness (talks loudly or softly)
- o Other

Fluency:

- o Student appears to stutter (speech has repetitions or prolongations)
- o Other

Expressive Language (Ability to verbally label/name language concepts):

- o Spoken vocabulary is delayed compared to peers
- o Student has difficulty using various language concepts
 - o Spatial concepts/prepositions (e.g. on, under, behind)
 - o Descriptive concepts/adjectives and adverbs (e.g. color words, long, rough, quickly)
 - o Temporal concepts/time concepts (e.g. first, last, night)
 - o Quantity concepts/number concepts (e.g. all, some, half, 1, 2, 3, 4)
- o Student has difficulty answering "wh" questions
- o Student uses incorrect grammar/syntax (e.g. She runned down the hall.)
- o Student has difficulty verbally relating experiences and stories in sequential order even when picture cues are available
- o Other

Receptive Language/Listening Comprehension (Ability to identify and understand various language concepts)

- o Student has difficulty identifying age appropriate objects/pictures compared to peers (vocabulary)
- o Student has difficulty identifying various language concepts:
 - o Spatial concepts/prepositions (e.g. on, under, behind)
 - o Descriptive concepts/adjectives and adverbs (e.g. color words, long, rough, quickly)
 - o Temporal concepts/time concepts (e.g. first, last, night)
 - o Quantity concepts/number concepts (e.g. all, some, half, 1, 2, 3, 4)
- o Student has difficulty following one, two, or three step directions (circle appropriate number)
- o Student has difficulty placing pictures of stories in sequential order
- o Other

Pragmatics (Ability to use language socially):

- o Student has difficulty making and sustaining friendships
- o Student has difficulty demonstrating and sharing his/her feelings
- o Student has difficulty interpreting body language
- o Student has difficulty detecting humor or sarcasm in the verbal expression of others
- o Student has difficulty with initiating, joining or maintaining a topic in conversation.
- o

Problem Solving Team: Ongoing Progress Monitoring (OPM) Data Worksheet

Name of Intervention Group: _____
 Frequent Duration (see PST 8) _____

Targeted Academic Skill/Targeted Behavior: _____

Intervention Program: _____ Intervention Strategy: _____

Teacher(s) Collecting PM Data: _____ Teachers(s) Conducting Group: _____

(Continue with Interventions if working)

♦ TIER 2 _____

♦ TIER 3 _____

MINUTE LOG - Specify the time in minutes (for each day of the week) you spent implementing the intervention for this group of students.

NOTE: It is NOT necessary to have minutes under every single day of the week. For instance, if you implement this group intervention three days a week, you may only have times under those three days.

Week of:	Monday	Tuesday	Wednesday	Thursday	Friday

Teachers should complete each time student tests to guide instruction in the intervention.

***If the student is absent, write absent on day of absence.**

Student	Progress Monitoring Data Points (s)		Progress Monitoring Data Points (s)		Progress Monitoring Data Points (s)		Progress Monitoring Data Points (s)		Progress Monitoring Data Points (s)		Progress Monitoring Data Points (s)	
	Date:		Date:		Date:		Date:		Date:		Date:	
1	SS	PR	SS	PR	SS	PR	SS	PR	SS	PR	SS	PR