

311 South East Street
Kingsland, GA 31548

Telephone: (912) 729-5687
Fax: (912) 289- 0244

Dr. William C. Hardin, Superintendent

CHECKLIST FOR *PRIVATE OR HOMESCHOOL* REFERRALS

Student Name: _____ **Date Sent:** _____

The following MUST be included altogether in order for an evaluation to proceed:

1. Enrollment Form
2. Parent Social and Developmental History
3. Teacher Referral Form (if applicable)
4. Passed Vision and Hearing Screening (within 1 year) DATE: V _____ H _____
5. Vision and Hearing Documentation Included (Georgia Form 3300)
6. Copy of student's Birth Certificate
7. Copy of student's Social Security card
8. Consent for Release of Confidential Information for *each* private therapy provider (if applicable)
9. Progress Monitoring Data **and/or**
Private Therapy Records: Initial Evaluation, Progress Notes, Most Recent Evaluation

Supplemental Documents (if available):

- Standardized Test Scores (e.g. GA Milestones, STAR, etc.)
- Student Work Sample(s) in each area of concern
- Most Recent Report Card or Annual Progress Report
- Psychological or other private evaluation
- Documentation of a medical diagnosis
- Discipline Record
- Functional Behavioral Assessment (FBA)/Behavior Intervention Plan (BIP)

SPEECH/LANGUAGE INFORMATION:

Y	N	Do you have concerns regarding this student's ability to speak clearly and/or use language?
Y	N	Is student receiving private speech/language services? If YES, attach <i>Release of Information</i> form

Office Use Only:

Date Consent to Evaluate sent to parent by school psychologist: _____

Date Consent to Evaluate received by school psychologist from parent: _____ (attached)

PLEASE PRINT

Official Use Only
Entry Date
School Entry Code

**CAMDEN COUNTY SCHOOLS
STUDENT DEMOGRAPHIC
AND ENROLLMENT INFORMATION**

Official Use Only
Homeroom
Revised 2/14

(School)

Student Social Security # _____ Grade _____ Age _____

Student's Name (Legal Name) _____
(Last) (First) (Middle)

Sex: M F Date of Birth ____/____/____ Place of Birth: City _____ State _____

Ethnicity: 1. Is the student Hispanic/Latino? (Check only one) No, not Hispanic/Latino Yes, Hispanic/Latino

2. Please select race(s) from list below. (Check all that apply) At least one must be checked.

American Indian or Alaska Native Black or African American

Native Hawaiian or Other Pacific Islander Asian White

Physical Address _____
House # Street Name Apt. # Subdivision

City State Zip Code

Mailing Address _____
Mailing Address Street Apt. #/Route/MIHP/Lot P.O.

City State Zip Code

Parent/Guardian (P/G) #1 Relationship Last 6 Digits of SSN

(P/G) #1 Home Address _____
House # Street Name City State Zip

(P/G) #1 Home Phone # _____ Cell Phone # _____

(P/G) #1 Parent Home Email Address _____

(P/G) #1 Employer _____ If Military-Command _____

(P/G) #1 Employer Work Address _____
Mailing Address City State Zip

(P/G) #1 Work Phone _____ Parent Work Email Address _____

Parent/Guardian (P/G) #2 Relationship Last 6 Digits of SSN

(P/G) #2 Home Address _____
House # Street Name City State Zip

(P/G) #2 Home Phone # _____ Cell Phone # _____

(P/G) #2 Parent Home Email Address _____

(P/G) #2 Employer _____ If Military-Command _____

(P/G) #2 Employer Work Address _____
Mailing Address City State Zip

(P/G) #2 Work Phone _____ Parent Work Email Address _____

Marital Status of Parents _____ (S=Single, M=Married, D=Divorced)

If Divorced, list the Custodial Parent _____

PLEASE PRINT

List All Siblings (Brothers and Sisters Attending Public School)	Name	Grade	Sex	School
	_____	_____	_____	_____
	_____	_____	_____	_____

Is the student a dependent of an active member of the Armed Forces? (Circle one) Yes No

Name _____ Relationship _____

MILITARY BRANCH _____ RANK _____

Do you live on Federal Property? (Circle One) YES NO If yes, Property _____

Are you a civilian employee working on Federal Property? (Circle One) YES NO

If yes: NAME _____ OFFICE or AGENCY _____

Is student classified as a migrant? (Circle one) YES NO If yes, List Migrant # _____

Is this your first year in a school in the United States? Yes _____ No _____

Is the student classified as an immigrant? Yes _____ No _____ (an immigrant student was not born in any US state, Puerto Rico, or the District of Columbia AND has not been attending one or more schools in any one or more states for more than 3 full academic years)

The purpose of the following questions is to determine if your child might be eligible for additional services under the McKinney-Vento Homeless Assistance Act of 2001.

1. Is the student currently living in a fixed, regular, and adequate nighttime residence? (circle one) YES NO
2. If the student's residence is only temporary please explain the circumstances. _____

If you answered NO to question 1, please contact the clerk or counselor at the neighborhood elementary school for more information to determine if your child is eligible for additional services under the Homeless Act.

As the parent/guardian completing this enrollment form, please list any other person(s) legally authorized to make changes on this form.

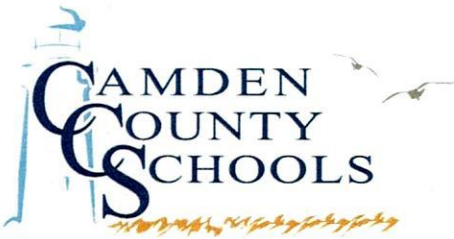
Name _____ Relationship _____

Name _____ Relationship _____

I understand that my signature below certifies that all information that I have provided on the enrollment form is accurate.

Signature of Parent/Guardian

Date



311 South East Street
Kingsland, GA 31548

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Dr. William C. Hardin, Superintendent

Parent Social and Developmental History

Name of Child: _____ Date of Birth: _____

Address: _____ Home Phone: _____

Place of Birth _____

Mother's Name: _____ Work or Cell Phone: _____

Mother's Occupation _____ Place of Employment: _____

Mother's Highest level of Education: _____

Father's Name: _____ Work or Cell Phone: _____

Father's Occupation _____ Place of Employment: _____

Father's Highest level of Education: _____

Name of parent or guardian with whom child lives _____

Marital status of parents: married separated divorced never married widowed

If separated, how old was the child when the separation occurred? _____ Is either parent remarried? Yes No

Stepfather's name: _____ Stepmother's name: _____

Does the child see the other parent? Yes No How often? _____

Is this student in foster care? Yes No If yes, when was the child placed in foster care? _____

Recent Traumatic Events _____

List all people living in household:

Name	Relationship to Child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If any brothers or sisters are living outside the home, list their names and ages:

Name	Relationship to Child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary language spoken in the home: _____ Other languages spoken in the home: _____

If Primary language is other than English, at what age did the child begin learning English? _____

Has the child ever lived in another country? Yes No If yes, where? _____ How long? _____

What language is spoken there? _____

BIRTH HISTORY

Was this child adopted? Yes No If yes, at what age was he/she adopted? _____

Is the child aware of the adoption? Yes No If yes, at what age did he/she learn of the adoption? _____

List any illnesses or accidents occurring during pregnancy: _____

Full Term: Yes No If No, how many weeks gestation? _____ weeks (Typical pregnancy is 40 weeks)

Birth Weight _____ pounds _____ ounces

Length of Labor _____ Apgar _____

Check any of the following complications that occurred during birth:

- | | |
|--|--|
| <input type="checkbox"/> Forceps used | <input type="checkbox"/> Labor induced |
| <input type="checkbox"/> Breech birth | <input type="checkbox"/> C-section |
| <input type="checkbox"/> Other delivery complications, describe _____ | |
| <input type="checkbox"/> Incubator: How long? _____ | |
| <input type="checkbox"/> Jaundiced: Bilirubin lights? No Yes If yes, how long? _____ | |
| <input type="checkbox"/> Breathing problems right after birth: Describe: _____ | |

Was there any evidence of injury at birth? Yes No If yes, describe: _____

As an infant, was the child quiet? Yes No As an infant, did the child like to be held? Yes No

As an infant, was the child alert? Yes No As an infant, did the child grow normally? Yes No

Were there any feeding problems as an infant? Yes No Describe _____

Were there any sleeping problems as an infant? Yes No Describe _____

DEVELOPMENTAL HISTORY

Does your child have a history of ear infections? Yes No

To the best of your memory, when did the following milestones first occur?	Early	Late	On time	Approximate Age
Sat without support <i>(most children develop this skill between 6-9 months)</i>				
Crawled <i>(most children develop this skill between 9-12 months)</i>				
Walked without assistance <i>(most children develop this skill between 12-18 months)</i>				
Spoke first words (besides ma-ma, da-da) <i>-(most children develop this skills between 12-18 months)</i>				
Put several words together <i>(most children develop this skill between 2- 3 years)</i>				
Toilet trained during day <i>(most children develop this skill by 3 years)</i>				
Toilet trained during night <i>(most children develop this skill under 5 years)</i>				
Dressed self except for tying shoes <i>(most children develop this skill by age 4)</i>				
Tied shoes				

CURRENT PHYSICAL CONDITION

My child's general condition is:

- | | | |
|---|--|-------------------------------------|
| <input type="checkbox"/> Seems to be in good health | <input type="checkbox"/> Underweight | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Tires easily, listless, lacks energy | <input type="checkbox"/> Overly active, always on the move | |
| <input type="checkbox"/> Sleeps too little | <input type="checkbox"/> Sleeps too much | |

MEDICAL HISTORY

Please indicate any illnesses or conditions that your child has had and the age of the child when he / she had the illness or condition.

	Year / Age of Child	
Hospitalization	_____	(Describe) _____
Surgery	_____	(Describe) _____
Allergies	_____	(Describe) _____
Asthma	_____	
Broken bones	_____	(Describe) _____
Chicken Pox	_____	
Epilepsy / Seizures	_____	
Head Injury	_____	(Describe) _____
High fever (above 104 degrees)	_____	
Tonsils or adenoids removed	_____	
Tubes in ears	_____	
Other	_____	(Describe) _____

Is the student currently under a doctor's care? Yes No If yes, who is the doctor? _____

What is the diagnosis / medical concern? _____

Is this child currently prescribed any medications? Yes No

If yes, what medication and how much? _____

Has your child taken any prescription medications in the past for more than 3 months? Yes No

If yes, what medication and how much? _____

Does this student use any of the following adaptive equipment? Eye glasses Hearing Aids Wheelchair Leg Braces

Walker Feeding Tube Other _____

Any other medical diagnosis / diagnoses? _____

COMMUNICATION SKILLS INVENTORY

(Please check all that best describe your child's communication skills)

- Speech is easily understood by familiar people
- Unfamiliar listeners have difficulty understanding him/her
- Student has difficulty using language for social communication
- Is able to follow short, single-step directions (close the door, stand up, sit down)

- Has difficulty following single-step directions
- Is able to follow two step directions (stand up, turn in a circle; Get dressed, make your bed)
- Has difficulty following multi-step directions
- Uses words to communicate wants and needs
- Uses gestures or other behaviors to communicate wants and needs

BEHAVIORAL CHECKLIST

(Please check the behaviors that best describe your child)

- | | | |
|---|--|--|
| <input type="checkbox"/> Feels happy with himself/herself | <input type="checkbox"/> Sucks his/her thumb | <input type="checkbox"/> Wets the bed |
| <input type="checkbox"/> Demands excessive attention | <input type="checkbox"/> Overly dependent on others | <input type="checkbox"/> Cries often |
| <input type="checkbox"/> Plays well with other students | <input type="checkbox"/> Overly anxious to please | <input type="checkbox"/> Poor self-control |
| <input type="checkbox"/> Exhibits uncooperative attitude | <input type="checkbox"/> Tries to control others | <input type="checkbox"/> Friendly |
| <input type="checkbox"/> Has very few close friends | <input type="checkbox"/> Relates well to adults | <input type="checkbox"/> Aggressive |
| <input type="checkbox"/> Lacks motivation, lazy | <input type="checkbox"/> Follows directions | <input type="checkbox"/> Sad or depressed often |
| <input type="checkbox"/> Does not adjust readily to change | <input type="checkbox"/> Fearful | <input type="checkbox"/> Shy, withdrawn |
| <input type="checkbox"/> Acts younger than other children his/her age | <input type="checkbox"/> Openly affectionate to family | <input type="checkbox"/> Daydreams often |
| <input type="checkbox"/> Can be trusted | <input type="checkbox"/> Restless, hard time sitting still | <input type="checkbox"/> Easily frustrated |
| <input type="checkbox"/> Talks excessively | <input type="checkbox"/> Loud | <input type="checkbox"/> Jealous of brother(s)/sister(s) |
| <input type="checkbox"/> Often loses things/disorganized | <input type="checkbox"/> Low Energy | <input type="checkbox"/> Engages in physically dangerous behaviors |
| <input type="checkbox"/> Deliberately does things to annoy others | <input type="checkbox"/> Often argumentative | <input type="checkbox"/> Rapid mood changes |
| <input type="checkbox"/> Sleeps too little/insomnia | <input type="checkbox"/> Explosive temper with minimal provocation | <input type="checkbox"/> Odd fascinations: _____ |
| <input type="checkbox"/> Suicidal thoughts/words | <input type="checkbox"/> Sleeps too much | <input type="checkbox"/> Fearful of groups |
| <input type="checkbox"/> Touches others inappropriately | <input type="checkbox"/> Suicidal Actions | <input type="checkbox"/> Attention problems |
| | <input type="checkbox"/> Angry | <input type="checkbox"/> Other: _____ |

ADAPTIVE BEHAVIOR

1. Describe any chores your child does around the house: _____

2. Describe any concerns with your child's self-help skills (e.g. bathing, toileting, fastening buttons or zippers, dressing appropriate for weather, brushing teeth, washing and brushing hair, caring for minor injuries, etc.). _____

3. Describe any concerns with your child's daily living skills (e.g. feeding self, cleaning up after self, preparing a snack or meal, answering the telephone, following safety rules in public, etc.) _____

4. Describe any concerns with your child's pre-vocational / vocational skills (e.g. telling time, counting money, making change, completing job application, following job schedule, etc.) _____

5. Describe any concerns with your child's communication skills? _____

6. Describe any concerns with your child's social skills? _____

7. Describe any concerns with your child's fine motor (using fingers) or gross motor (walking / running) skills? _____

DISCIPLINE USED AT HOME

1. Child is disciplined (check one) frequently occasionally rarely
2. Punishment is administered by mother father others (check all that apply)
3. What type of discipline is used? (check all that apply)
 spanking loss of privileges restricted from preferred activity
 time-out talking rewards
4. Reactions to discipline: becomes angry cries withdraws sulks and pouts fights back
5. Effectiveness of discipline: behavior improves remains the same behavior changes behavior worsens

OTHER INFORMATION

1. What activities do you do together as a family? _____
 2. Describe your child's relationship with family, classmates, friends, etc: _____

 3. List your child's major interests (sports, hobbies, activities) _____

 4. What time does he/she go to bed on school nights? _____ What time does he/she get up for school? _____
 5. What concerns you most about your child? _____
 6. What do you enjoy most about your child? _____
 7. Has your child ever had a psychological evaluation? Yes No If yes, with whom and when? _____

 8. Has your child ever seen a psychiatrist? Yes No If yes, who? _____
 9. Has a private psychologist or psychiatrist given the child any diagnoses? Yes No If yes, what? _____
 10. Has your child received any private counseling? Yes No If yes, with whom and when? _____
 11. Has your child been involved with the court system? Yes No If yes, in what way? _____
- Does the student currently receive any therapies outside of school (occupational, physical, speech and/or language, counseling, ABA)? Yes No If yes, who is the therapist (s)? _____

12. What would you like to learn from the evaluation? _____

SENSORY BEHAVIORS

Is your child overly sensitive to light, noise or touch? Yes No If yes, describe: _____

Is your child a picky eater? Yes No If yes, describe: _____

Is your child overwhelmed by large groups? If yes, describe: _____

Is your child overwhelmed by unexpected noises? If yes, describe: _____

LEARNING BEHAVIORS / INFORMATION PROCESSING (Please check the learning behaviors that best describe your child)

- | | |
|---|---|
| <input type="checkbox"/> Frequently asks for repetitions of instructions/explanations | <input type="checkbox"/> Difficulty solving problems that a younger child can do |
| <input type="checkbox"/> Quickly learns new information | <input type="checkbox"/> Responds slowly when asked questions |
| <input type="checkbox"/> Has trouble repeating directions that were just given | <input type="checkbox"/> Recalls information accurately and quickly |
| <input type="checkbox"/> Loses track of steps/forgets what he/she is doing amid task | <input type="checkbox"/> Difficulty answering questions about a story read to him/her |
| <input type="checkbox"/> Learns information one day, but has trouble recalling it later | <input type="checkbox"/> Knowledge of basic math facts not at grade/age level |
| <input type="checkbox"/> Forgets where personal items and/or school work was left. | <input type="checkbox"/> Makes careless mistakes while solving math problems |
| <input type="checkbox"/> Always turns in homework on time | <input type="checkbox"/> Has difficulty copying letters/words |
| <input type="checkbox"/> Forgets to turn in homework assignments | <input type="checkbox"/> Has difficulty with letter formation |
| <input type="checkbox"/> Learns best when given verbal material | <input type="checkbox"/> Has difficulty copying from the board |
| <input type="checkbox"/> Difficulty learning verbal information | <input type="checkbox"/> Does well on timed tests / tasks |
| <input type="checkbox"/> Learns best when given visual material | <input type="checkbox"/> Requires extra time to complete tests / tasks |
| <input type="checkbox"/> Difficulty learning visual information | <input type="checkbox"/> Has difficulty with timed tasks |
| <input type="checkbox"/> Difficulty learning new concepts | <input type="checkbox"/> Difficulty answering questions about a story he/she has read |

SCHOOL HISTORY

Does / Did the student attend preschool / pre-kindergarten? Yes No If yes, where? _____

Describe any problems noted in preschool / pre-kindergarten: _____

How old was the student when he/she entered kindergarten? _____ Where did the student attend kindergarten? _____

Has the student ever been retained? Yes No Grades Repeated _____

Other schools attended _____

List any subjects that are especially difficult for your child. _____

Describe any serious problems your child has experienced at school _____

Describe your child's study habits at home: _____

How much time is spent on homework each night? _____

Describe the after school care the child receives: _____

Has your child received any of the following services in school?

- ESOL (English for Speakers of Other Languages)
- After school tutoring
- 504 Accommodation Plan
- Rtl (Response to Intervention) plan

Has your child received special education services or had an individual education plan (IEP) in the past? Yes No

If yes, when and what type? _____

Has your child received any outside / private tutoring? Yes No If yes, where and for how long? _____

Has your child received in private speech therapy, occupational therapy or physical therapy? Yes No

If yes, what type, where and how long? _____

HIGH SCHOOL STUDENTS ONLY

Does the student work outside the home? Yes No Where? _____

If yes, how many hours does he/she work during the week? _____ On the weekend? _____

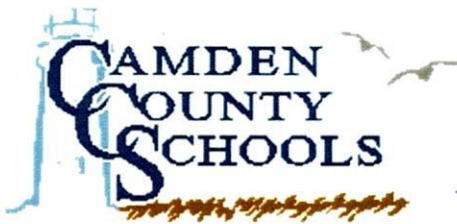
Does this student have a driver's license? Yes No

ADDITIONAL INFORMATION (All STUDENTS)

Any additional comments or concerns? _____

Name of person completing this form

Date



311 South East Street
Kingsland, GA 31548

Telephone: (912) 729-5687
Fax: (912) 289-0244

Dr. William C. Hardin, Superintendent

Teacher Referral Form

Referring Teacher: _____ Date Referral Completed: _____
 Grade: _____ Student Name: _____
 School: _____ Date of Birth : _____

Referral Information

Area of strength: _____
 Area of concern(s): _____

Identify student's area(s) of concern: (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Academic (Circle specific areas below)
<input type="checkbox"/> Basic reading
<input type="checkbox"/> Reading fluency
<input type="checkbox"/> Reading comprehension
<input type="checkbox"/> Math computation
<input type="checkbox"/> Math reasoning
<input type="checkbox"/> Written expression
<input type="checkbox"/> Other (Describe)
_____ | <input type="checkbox"/> Behavior (Circle specific areas below)
<input type="checkbox"/> On task/off task
<input type="checkbox"/> Verbal aggression
<input type="checkbox"/> Physical aggression
<input type="checkbox"/> Disruption
<input type="checkbox"/> Social skills
<input type="checkbox"/> Other (Describe)
_____ | <input type="checkbox"/> Speech/Language (Circle specific areas below)
<input type="checkbox"/> Articulation
<input type="checkbox"/> Language
<input type="checkbox"/> Other (Describe)
_____ |
|--|---|--|

SCHOOL HISTORY

	Present school year	Prior school year
Number of absences		
Number of tardies/checkouts		

Has the student ever been retained? Yes No Grades Repeated _____
 Other schools attended _____
 List any subjects that are especially difficult for this child _____
 Describe any serious problems the child has experienced at school _____
 Disciplinary History: Number of office referrals: _____ Days suspended _____
 Reason (s) for suspension: _____

Has the child received any of the following services in school?

- | | |
|---|--|
| <input type="checkbox"/> ESOL (English for Speakers of Other Languages) | <input type="checkbox"/> 504 Accommodation Plan |
| <input type="checkbox"/> After school tutoring | <input type="checkbox"/> RTI (Response to Intervention) plan |

Has the child received special education services or had an individual education plan (IEP) in the past? Yes No

If yes, when and what type? _____

MEDICAL HISTORY

List any known medical concerns and prescribed medication. _____

List any known involvement with outside agencies (medical specialists, special clinics, social agencies, etc.)

COMMUNICATION SKILLS INVENTORY

(Please check all that best describe the student's communication skills)

- Speech is easily understood by familiar people
- Unfamiliar listeners have difficulty understanding him/her
- Student has difficulty using language for social communication
- Is able to follow short, single-step directions (close the door, stand up, sit down)
- Has difficulty following single-step directions
- Is able to follow two step directions (Stand up, turn in a circle/Put your folder away, sit down)
- Has difficulty following multi-step directions
- Uses words to communicate wants and needs
- Uses gestures or other behaviors to communicate wants and needs

BEHAVIORAL CHECKLIST

(Please check the behaviors that best describe the student)

- | | | |
|---|--|--|
| <input type="checkbox"/> Appears happy with himself/herself | <input type="checkbox"/> Sucks his/her thumb | <input type="checkbox"/> Toileting accidents |
| <input type="checkbox"/> Demands excessive attention | <input type="checkbox"/> Overly dependent on others | <input type="checkbox"/> Cries often |
| <input type="checkbox"/> Plays well with other students | <input type="checkbox"/> Overly anxious to please | <input type="checkbox"/> Poor self-control |
| <input type="checkbox"/> Exhibits uncooperative attitude | <input type="checkbox"/> Tries to control others | <input type="checkbox"/> Friendly |
| <input type="checkbox"/> Has very few close friends | <input type="checkbox"/> Relates well to adults | <input type="checkbox"/> Aggressive |
| <input type="checkbox"/> Has friends at school | <input type="checkbox"/> Follows directions | <input type="checkbox"/> Sad or depressed often |
| <input type="checkbox"/> Does not adjust readily to change | <input type="checkbox"/> Fearful | <input type="checkbox"/> Shy, withdrawn |
| <input type="checkbox"/> Acts younger than other children his/her age | <input type="checkbox"/> Openly affectionate to teachers | <input type="checkbox"/> Daydreams often |
| <input type="checkbox"/> Can be trusted | <input type="checkbox"/> Restless, hard time sitting still | <input type="checkbox"/> Easily frustrated |
| <input type="checkbox"/> Talks excessively | <input type="checkbox"/> Loud | <input type="checkbox"/> Jealous of others |
| <input type="checkbox"/> Often loses things/disorganized | <input type="checkbox"/> Low Energy | <input type="checkbox"/> Engages in physically dangerous behaviors |
| <input type="checkbox"/> Deliberately does things to annoy others | <input type="checkbox"/> Often argumentative | <input type="checkbox"/> Rapid mood changes |
| <input type="checkbox"/> Sleeps in class | <input type="checkbox"/> Explosive temper with minimal provocation | <input type="checkbox"/> Odd fascinations: _____ |
| <input type="checkbox"/> Suicidal thoughts/words | <input type="checkbox"/> Asks to see the nurse/go home | <input type="checkbox"/> Fearful of groups |
| <input type="checkbox"/> Touches others inappropriately | <input type="checkbox"/> Suicidal Actions | <input type="checkbox"/> Attention problems |
| | <input type="checkbox"/> Angry | <input type="checkbox"/> Other: _____ |

ADAPTIVE BEHAVIOR

1. Describe any difficulties with following school routines: _____

2. Describe any concerns with self-help skills (e.g. toileting, fastening buttons or zippers, eating, personal hygiene). _____

3. Describe any concerns with the child's daily living skills (e.g. cleaning up after self, following safety rules, following classroom routines, etc.) _____

4. Describe any concerns with the child's pre-vocational / vocational skills (e.g. telling time, counting money, making change, etc.) _____

5. Describe any concerns with the child's communication skills? _____

6. Describe any concerns with the child's social skills? _____

7. Describe any concerns with the child's fine motor (using fingers) or gross motor (walking / running) skills? _____

SENSORY BEHAVIORS

- Is the child overly sensitive to light, noise or touch? Yes No If yes, describe: _____

- Is the child a picky eater? Yes No If yes, describe: _____

- Is the child overwhelmed by large groups? Yes No If yes, describe: _____

- Is the child overwhelmed by unexpected noises? Yes No If yes, describe: _____

LEARNING BEHAVIORS/INFORMATION PROCESSING

(Please check the learning behaviors that best describe the child)

- | | |
|---|---|
| <input type="checkbox"/> Frequently asks for repetitions of instructions/explanations | <input type="checkbox"/> Difficulty solving problems that a younger child can do |
| <input type="checkbox"/> Quickly learns new information | <input type="checkbox"/> Responds slowly when asked questions |
| <input type="checkbox"/> Has trouble repeating directions that were just given | <input type="checkbox"/> Recalls information accurately and quickly |
| <input type="checkbox"/> Loses track of steps/forgets what he/she is doing amid task | <input type="checkbox"/> Difficulty answering questions about a story read to him/her |
| <input type="checkbox"/> Learns information one day, but has trouble recalling it later | <input type="checkbox"/> Knowledge of basic math facts not at grade/age level |
| <input type="checkbox"/> Forgets where personal items and/or school work was left | <input type="checkbox"/> Makes careless mistakes while solving math problems |
| <input type="checkbox"/> Always turns in homework on time | <input type="checkbox"/> Has difficulty copying letters/words |
| <input type="checkbox"/> Forgets to turn in homework assignments | <input type="checkbox"/> Has difficulty with letter formation |
| <input type="checkbox"/> Learns best when given verbal material | <input type="checkbox"/> Has difficulty copying from the board |
| <input type="checkbox"/> Difficulty learning verbal information | <input type="checkbox"/> Does well on timed tests / tasks |
| <input type="checkbox"/> Learns best when given visual material | <input type="checkbox"/> Requires extra time to complete tests / tasks |
| <input type="checkbox"/> Difficulty learning visual information | <input type="checkbox"/> Has difficulty with times tasks |
| <input type="checkbox"/> Difficulty learning new concepts | <input type="checkbox"/> Difficulty answering questions about a story he/she has read |

ADDITIONAL INFORMATION

Any additional comments or concerns? _____



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Dr. William C. Hardin, Superintendent

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

TO: _____

RE: _____ (Student's Name) _____ (Birthdate)

I hereby authorize you to release the following documents:

- | | |
|--------------------------------------|--------------------------------------|
| _____ Placement Committee Minutes | _____ Psychological Reports |
| _____ Parental Consent for Placement | _____ Speech and Language Evaluation |
| _____ Educational Screening | _____ Current IEP |
| _____ Medical and Social History | _____ OTHER _____ |
| _____ Eligibility Report | _____ Progress Monitoring Data |

PLEASE FORWARD THIS INFORMATION TO THE FOLLOWING ADDRESS:

_____ Camden County Schools
_____ 311 S. East Street
_____ Kingsland, GA 31548

This information will be used in the placement and planning of my child's educational program. I understand that granting this consent is voluntary on my part. It is understood that the party to whom this information is released may release it to a third party, if that party has written consent. This authorization will expire 60 days from the date below. I understand that I may revoke this authorization at anytime by contacting the Camden County Schools special education department at 729-5687.

_____ (Parent or Legal Guardian)

_____ Date Records Mailed

_____ (Date)

Intervention and Progress Monitoring How To:

I. Getting Started:

- 1) Identify the student's area of suspected weakness (e.g. basic reading skills, math reasoning).
- 2) Select an *intervention*.
 - a) An intervention is a program or instructional strategy that aims to improve upon the student's area of weakness. Programs that have been found effective through research are best! See the *Response to Intervention Guide* provided in this packet to help select an appropriate intervention.
 - b) If the student has more than one area of weakness, identify an appropriate intervention *for each*.
 - c) Consider targeting a basic skill at first, and work towards more advanced skills if the student demonstrates progress.
- 3) Once an intervention has been selected, determine how you intend to measure the student's progress towards developing their area of weakness. Measuring a student's skills over time is called *progress monitoring*.
 - a) Some intervention programs have built-in assessments.
 - b) Use the *Response to Intervention Guide* provided in this packet to assist you in determining an appropriate progress monitoring tool or method.

II. Obtaining a Baseline Measure:

- 1) After selecting a weakness to target, an intervention, and a tool/method for progress monitoring, obtain a *baseline measure*.
 - a) A *baseline measure* is a measure of how the student performs on the progress monitoring tool **before** the student is exposed to the intervention. The student's performance/score on the baseline will help you to understand how your student is performing currently, and help you later on to determine if the child is making progress with the intervention in place.
- 2) Record the baseline score on the *Progress Monitoring Data Sheet*.

III. Completing the Progress Monitoring Data Sheet:

- 1) Fill in the *Progress Monitoring Data Sheet* with the following information:
 - a) Description of Intervention
 - i. What skills does the intervention aim to address?
 - ii. How often will the intervention be used (e.g. 3 times/week)?
 - iii. How long will each intervention session last (e.g. 20 minutes)?
 - iv. Who will administer the intervention (e.g. teacher, parent, tutor)?
 - b) Indicate how often the student will be re-tested (e.g. Once per week)
 - i. Note: You will use the same progress monitoring tool/method as the baseline measure!
 - ii. It may be helpful to fill in the anticipated "test" dates on the data sheet to ensure you collect data systematically
 - c) After each "test," record the student's score in the box corresponding to the date

IV. Fill in the *Intervention Fidelity Document*:

- 1) After administering the baseline measure, implement the intervention as often and for as long as you indicated on the *Progress Monitoring Data Sheet*.
- 2) After each intervention session, record the date on the *Intervention Fidelity Document*.
 - a) It may be helpful to keep notes on the student's engagement and success with the intervention as he or she is working. This will help you later on to analyze the student's progress or *response* to the intervention.

V. Analyze Progress Monitoring Data:

- 1) After several weeks of collecting data on the student's progress with the intervention, determine if the student is making adequate growth.

Consider:

- a) Is the student's current performance higher or better than the baseline measure?
 - b) Is the student's performance improving consistently (e.g. each score better than the last?)
 - c) Whenever possible, compare your student's current performance/score with other children his or her age. This will help you to determine if your student is below average, and in need of continued intervention support.
- 2) If the student's skills are improving, continue the intervention and data collection.
 - a) Analyze data again in several weeks to determine if the student continues to make growth; or is now demonstrating average or typical skills; or if a more advanced skill should be targeted instead.
 - 3) If the student's skills do not appear to be improving consistently or are improving very slowly (and still below average), it may be necessary to change or modify the intervention.

VI. Modifying or Changing the Intervention:

- 1) Consider:
 - a) Modifying current intervention (e.g. increasing how often or the length of time with which the student participates in the intervention, small group vs individual)
 - b) Changing the intervention to address the *same* skill
 - c) Changing the intervention to address a *different* skill
 - Only address a different skill if you feel confident the student's issues may be better served by addressing a different skill
 - For example, "John" may perform better with math word problems if he improves his calculation skills
- 2) If an intervention is changed, start a new *Progress Monitoring Data Sheet* (see steps I-III)
- 3) If the intervention stays the same but is modified in some way, indicate changes and date started on the same data sheet.

Response to Intervention Guide

Area	Intervention Resources	Suggested Frequency	Progress Monitoring Strategies	Frequency of Data Collection
Phonemic Awareness (Pre-literacy skills)	<ul style="list-style-type: none"> • FCRR Activities • Fcrr.org/curriculum/studentcenteractivities.shtm • Hello Two Peas in a Pod (listening games) 	3-5 times per week	<ul style="list-style-type: none"> • Identify Letter Names • Identify Letter Sounds • Rhyming Words • Breaking apart words to say individual letter sounds (e.g. "C-A-T"). <p>Record # correct out of fixed number of trials; determine percentage (e.g. 5 out of 10= 50%)</p>	Weekly to biweekly
Decoding/Phonics (Basic reading skills)	<ul style="list-style-type: none"> • FCRR Activities (see above) • Barton Phonics • Jack and Jilly Readers • Journey's Intervention kit 	3-5 times per week	<ul style="list-style-type: none"> • Word Reading Fluency: # of sight words read per minute 	Biweekly
Reading Fluency (Quick and accurate reading)	<ul style="list-style-type: none"> • Echo reading • Repeated use of Fry phrases • www.readingsource.net/support-files/shortfluencyphrases.pdf 	3-5 times per week	<ul style="list-style-type: none"> • Word Reading Fluency: # of sight words read per minute • Passage Reading Fluency: # of words read per minute in paragraph form 	Biweekly
Reading Comprehension	<ul style="list-style-type: none"> • SRA Reading Skills series • Guided reading instruction 	3-5 times per week	<p>Fill in the blank or multiple choice questions pertaining to the text (e.g. recalling details, inferencing, etc.); monitor percent correct out of fixed # of questions</p>	Biweekly
Math Fluency (Quick and accurate calculation of math facts)	<ul style="list-style-type: none"> • Repeated drill and practice of math facts • Practicing with manipulatives and concepts such as base-10 blocks 	3-5 times per week	<ul style="list-style-type: none"> • Target one operation at a time (e.g. addition, subtraction, multiplication, division) • Build from one-digit to two-digit; carrying to borrowing 	Weekly to biweekly
Math Reasoning (Applying math concepts)	<ul style="list-style-type: none"> • Selected guided instruction using Quantiles.com • Number Worlds 	3-5 times per week	<ul style="list-style-type: none"> • Percent correct of fixed number of questions; continue with same math concept until mastered with 80% accuracy 	Biweekly
Writing * Be sure to rule out reading concerns first.	<ul style="list-style-type: none"> • Editing errors in incorrect sentences presented • Fill in the blank to practice correct use of grammar • Use of a spacer • Practice with graphic organizers • Guided writing prompts 	1-3 times per week	<ul style="list-style-type: none"> • Target individual skills (one at a time); and calculate % of sentences containing 0 errors <ul style="list-style-type: none"> - Syntax - Grammar - Mechanics (e.g. capitalization, punctuation, spacing between words) 	Biweekly

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			<ul style="list-style-type: none"> • Writing prompts; score according to grade-level standards 	
Spelling	<ul style="list-style-type: none"> • Repeated practice of sets of spelling words • May align with sight words presented (e.g. Dolch, Fry word lists) 	3-5 times per week	<ul style="list-style-type: none"> • Practice sets of spelling words; calculate % spelled correctly • Select new set of words once student masters with 80% accuracy 	Weekly to biweekly
Behavior	<ul style="list-style-type: none"> • Daily behavior plan/chart: rewarding appropriate behavior • Social stories with adult • Modeling or role-playing appropriate behavior • Emotionalabcs.com • Skillstreaming Lessons • Zones of Regulation • Second Step • The Mood Meter 	Varies depending on the intervention	<p>Record frequency (tally marks) and/or duration (stop watch) of problematic behavior</p> <p>Record instances in which student used appropriate coping skills or behavior (tally marks)</p> <p>Task Analysis: Break steps of a task (e.g. dressing self) into individual steps. Record (+) for each step student does independently; calculate # of (+) out of total number of steps to determine percentage.</p>	Daily to weekly; summarized weekly

Additional Online Resources for Students:

Reading/ Language Arts:

- http://www.abcy.com/dolch_sight_word_bingo.htm
- <http://www.k12reader.com/subject/reading-skills/reading-comprehension/5th-grade-reading-comprehension-worksheets/>
- <https://www.superteacherworksheets.com/4th-comprehension.html>
- <http://www.englishforeveryone.org/Topics/Sentence-Correction.htm>
- [http://www.learninggamesforkids.com/keyboarding_games/keyboarding_g_games_typing_speed_test.html](http://www.learninggamesforkids.com/keyboard_games/keyboarding_g_games_typing_speed_test.html)
- <http://www.k12reader.com/subject/reading-skills/main-idea-worksheets/>
- <http://www.k5learning.com/free-flashcards/reading/fry>
- <https://www.mesacc.edu/~paaih30491/PointofView.html>
- <https://k12.thoughtfullearning.com/minilesson/analyzing-writing-prompts>
- <https://www.getepic.com/>
- <http://www.fcrr.org/>
- <http://www.readwritethink.org/>
- <https://www.typingclub.com/>
- <https://readtheory.org/>
- <https://www.sadlierconnect.com/vw/vocabularyworkshop.com#null>

Response to Intervention Guide

Mathematics:

- <https://www.varsitytutors.com/aplusmath/flashcards>
- <https://xtramath.org/#/home/index>
- https://www.harcourtschool.com/activity/thats_a_fact/english_K_3.htm
- <http://www.arcademics.com/>
- <https://www.funbrain.com/pre-k-and-k-k-playground>
- <http://www.mathgametime.com/>
- <http://www.mathplayground.com/>
- <http://www.softschools.com/math/games/>
- <http://pbskids.org/games/math/>
- <http://www.hoodamath.com/mobile/games/>
- <http://www.coolmath-games.com/>
- <http://www.physicsgames.net/>
- <http://interactivesites.weebly.com/areaperimeter.html>

- <http://www.shodor.org/interactivate/activities/ShapeExplorer/>
- http://www.abcya.com/measuring_angles.htm
- <http://www.visnos.com/demos/basic-angles>
- <http://www.crickweb.co.uk/ks2numeracy-tools.html#angle>
- <http://www.mathplayground.com/measuringangles.html>
- <http://illuminations.nctm.org/activity.aspx?id=3510>
- <https://www.smartamp.com/start>
- <https://app.studyisland.com/cfw/login/>
- http://www.glencoe.com/sites/common_assets/mathematics/ebook_asses/vmf/VMF-Interface.html
- <https://learnzillion.com/login#student-login>
- <https://www.mathlearningcenter.org/web-apps/number-pieces/>
- <http://www.calculatorsoup.com/calculators/conversions/numberstowords.php>
- https://www-k6.thinkcentral.com/content/hsp/math/hspmath/na/gr3-5/tools_intermediate_9780547274058/_main.html