OCONEE COUNTY SCHOOLS

Please mail or fax the completed referral to:

Oconee County Schools
Special Services Department
P. O. Box 146
Watkinsville, GA 30677
FAX (706) 310-2022

The enclosed information is required prior to consideration of eligibility for special education services. Please complete all areas and return to the Special Services Department. If assistance is needed please contact us at (706) 769-7941 ext. 1047.

1. Child Find Referral Form: To be completed by the student's parent or teacher.
2. Student History: To be completed by the child's parent/guardian
3. Hearing and Vision Screening Form: To be completed by physician, Health Department, audiologist, or trained school personnel. A child must pass both areas before he/she can participate in individual assessments.
4. Outside Evaluations or Medical Reports: Any outside evaluations that may impact your child in an educational setting would be beneficial.
5. Intervention Form: To be completed by person implementing interventions.
6. Student Information/Enrollment Sheet: To be completed by child's parent/guardian.
7. Certificate of Immunization form 3231: To be completed by child's physician or the local Health Department.
8. Copy of Birth Certificate
9. Copy of Social Security Card
10. Proof of Residency: A student may not be enrolled until at least one of the listed requirements below has been met for verification of residency:
    - Copy of a current utility bill with your name and address listed on it
    - Copy of a Purchase Agreement with your name, closing date, street address and signature page, followed by the closing paperwork and current utility bill
    - Copy of a current Lease Agreement. This should have names, signatures and dates, otherwise, you will need to fill out a "Residency Affidavit" and have it notarized.
    - If you are living in another person's residence, a "Residency Affidavit" will have to be completed, notarized and returned to the school along with a current utility bill in the name of the homeowner/lessor with whom you live. In addition, you will need to follow up with a current utility bill or other mail in your name at that address.

The parent/guardian will be contacted by the appropriate school system personnel upon receipt of the completed referral packet.

OCONEE COUNTY SCHOOLS
34 SCHOOL STREET, P.O. BOX 146
WATKINSVILLE, GA 30677
(706) 769-5130
(706) 310-2022 FAX

Dr. Jason L. Branch, Superintendent

CHILD FIND REFERRAL

Date of Referral: _____, 20____

Child's Name: _____ Date of Birth: _____

Social Security Number: _____ School Attending: _____

Name of Parent/Guardian: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

Cell Phone: _____

Please explain reason for referral: _____

_____

_____

Person Making Referral: _____

Address: _____

Phone: _____

Office Use Only

Received on: _____, 20____

Staff Member Responsible: _____

Parent Contacted On: _____, 20____

Oconee County School System
Student Support Services
34 School Street P.O. Box 146
Watkinsville, Georgia 30677
Phone: 706-769-3506 Fax: 706-769-3513

STUDENT HISTORY

Completion Format: ☐ Questionnaire ☐ Interview

Directions: Please complete this form as accurately as possible and return it to the school as soon as is practical. If you need more room to answer any question(s) please use extra paper and/or the extra space provided on the last page.

Child's name: _____ Birth date: _____ Age: _____

Address: _____ Sex: ____ Male ____ Female

Home phone: _____ Cell phone: _____ Work phone: _____

Email: _____ School: _____ Grade: _____

Person Answering Questions: _____ Relationship to child: _____

Best Way to Reach You: ___home phone ___email ___work phone Today's date: _____

Parent(s) With Whom The Child Lives

Please provide the following information for each parent, step-parent, and/or caregiver **with whom the child lives**.

Name: _____ Name: _____

Relationship to child: _____ Relationship to child: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Work Phone: _____ Work Phone: _____

Highest level of education: _____ Highest level of education: _____

Other Parent(s) / Caregivers

If the child has parent(s), step-parent(s), and/or caregivers **other than the ones listed above**, please provide the following information for each.

Name: _____ Name: _____

Relationship to child: _____ Relationship to child: _____

How often does he/she see this individual? _____ How often does he/she see this individual? _____

Does the child attend after-school day-care? _____ Where? _____ Hours per day? _____

Family Information

Is this child adopted? _____ If yes, at what age? _____ Please explain the circumstances. _____

_____

Has the child experienced parental separation, divorce, or other possibly traumatic childhood experiences? _____ If yes, how old was the child at the time? _____ Please describe the situation.

_____

_____

Please list **all** brothers, sisters, and **any others living in the home**.

Name	Age	Relationship to child	Living at home (yes/no)

What language(s) are spoken in the home? _____

What was this child's first language? _____

What are this child's most positive qualities? _____

_____

What are the biggest challenges of being a parent to this child? _____

_____

How often is discipline required? _____ What method of discipline works the best ? _____

List some things your child does that require discipline. _____

_____

What is the **highest** level of education that you expect this child will complete? (Check one) ____ High School

____ Vocational school ____ Two year college ____ Four year college ____ Graduate, medical, or law school

Please explain any special situations **currently occurring** within the family that might be impacting this child's school performance? _____

_____

Have any family members ever received special education services or had difficulties in school? _____ Explain: _____

_____

Has the child experienced any of the following? (Check all that apply)

_____ Death of Parent _____ Jail Sentence of Parent _____ Marriage of Parent to Stepparent
_____ Moves _____ Illness Requiring Hospitalization _____ Death of Family Member
_____ Illness of Parent Requiring Hospitalization _____ Death of Close Friend

Check the activities in which this child often participates with the family:

_____ Movies _____ Meals _____ Games _____ Sports
_____ Visits with Relatives _____ Television _____ Trips _____ Church

Medical History

Pregnancy: Were any of the following complications present **during** the pregnancy with this child? (Check all that apply)

_____ Lack of medical care _____ Measles _____ Gestational Diabetes
_____ High blood pressure _____ Toxemia _____ Drug use, Frequency _____ Type_____
_____ Maternal injury _____ Alcohol use, Frequency _____
_____ Cigarette use, Frequency _____
_____ Hospitalization : Please Explain:_____

_____ Medication(s) used: Please Explain: _____

_____ Other complication: Please Explain:_____

Birth: Check all of the following complications that were present during or soon after this child's birth.

_____ Forceps used _____ Breech birth _____ Labor induced _____ Caesarian delivery _____ Jaundiced
_____ Incubator used _____ Breathing problems: Was supplemental Oxygen used? _____ How long? _____
_____ Other complications: Explain: _____

Length of pregnancy: _____ wks. Length of labor: _____ hrs. Mother's condition at birth: _____

Child's condition at birth: _____ Birth weight: ____ lbs. ____ oz.

Mother's age at birth: _____ Length of hospital stay: Mother: _____ Child: _____

Childhood Medical History: Check the illnesses and/or conditions that apply to this child.

_____ Asthma _____ Frequent stomachaches _____ Frequent headaches _____ Heart condition
_____ Anemia _____ Meningitis _____ Seizures/Epilepsy _____ Eating disorder
_____ Awkward walk _____ Poor posture _____ Diagnosed attention problems and/or hyperactivity
_____ Chicken pox _____ Measles _____ Scarlet Fever _____ Strep Infection
_____ Food allergies: List: _____
_____ Allergy to medicine(s): Explain: _____
_____ Other allergies: List: _____
_____ Head Injury: Describe: _____
_____ Coma or loss of consciousness: Describe: _____
_____ Prolonged high fever(s): Explain: _____
_____ Operation(s): Explain: _____
_____ Hospitalization(s): Explain: _____
_____ Long-term medications in the past (at least one month): Please List: _____
_____ Current medications: Please List:_____
_____ Frequent ear infections: Have ear tubes been inserted? _____ When? _____
_____ Hearing problem: Explain: _____
_____ Vision problem: Explain: _____ Wears glasses or contacts? _____
_____ Other health problem or condition: Explain: _____

Family History: Have any family members had or have been considered to have the following? Check all that apply **and** indicate in the blank the relationship of the family member to the child.

_____ Physical disability _____
_____ Seizures or epilepsy _____
_____ Drug abuse _____
_____ Alcohol abuse _____
_____ Autism Spectrum Disorder _____
_____ Bipolar Disorder _____
_____ Behavior disorder _____
_____ Depression _____
_____ Learning disability _____
_____ Math problem _____
_____ Reading problem _____
_____ Speech or language problem _____
_____ Attention Problems /Hyperactivity _____
_____ Cognitive delay/Intellectual Disability _____
_____ Tourette's Syndrome _____
_____ Other: Explain: _____

Child Development

At what age did this child do the following:

_____ Sit unsupported _____ Walk Alone _____ Speak first words

_____ Speak in two-word sentences

At what age was the child successfully toilet trained? Days: _____ Nights: _____

Did bed wetting occur after toilet training? _____ How often? _____ Until what age? _____

Were there any medical reasons for bed wetting? _____ Explain: _____

Does or did this child experience any of the following difficulties **during the first four years**: (Check all that apply)

_____ Feeding/Eating problem
_____ Colic
_____ Underweight
_____ Overweight
_____ Failure to thrive
_____ Malnutrition
_____ Delayed language development
_____ Unclear speech
_____ Difficulty separating from parent(s)
_____ Tempter Tantrums
_____ Sleeping too little
_____ Sleeping too much
_____ Walking difficulty
_____ Difficulty learning to throw or catch

Educational History

Is this child frequently absent from school? _____ If yes, explain? _____

Other than for reasons of typical grade promotion, has this child changed schools? _____ If yes, explain. _____

Has this child been retained in any grade? _____ If yes, which grade? _____ Why? _____

Has this child skipped a grade in school? _____ If yes, which grade? _____ Why? _____

Has this child ever been tested for special education? _____ When? _____ Where? _____

Is this child currently receiving special education services? _____ If yes, what type of class _____

Does this child like going to school? _____

Does or did this child attend preschool? _____ Where? _____ At what age? _____

Amount of time per day _____ Days per week _____

Please describe any problems that your child has had in school in the past. _____

_____

_____

Please describe your child's current school difficulties. _____

_____

_____

Behavioral/Social/Emotional Development

Friendships:

How does this child get along with other children? _____

How many friends does this child have? (Check one) _____ None _____ Few _____ Some _____ Many

Does this child have difficulty making friends? _____ Does this child prefer to play alone? _____

With what age individuals does this child prefer to play/associate? (circle one) Younger Same age Older/adults

Outside Interests:

What activities does this child enjoy? _____

Please list after school activities in which your child participates _____

Has this child's interest or participation in these activities decreased lately? _____ Explain: _____

_____

Behavior/Temperament: Please indicate whether your child **currently** exhibits any of the following behaviors, emotions, or personality traits. Check all that apply.

_____ Accident prone	_____ Forgetful	_____ Easily upset/Irritable
_____ Over-stimulation in play	_____ Unreasonable fears	_____ Thumb sucking
_____ Short attention span	_____ Worries excessively	_____ Has many physical complaints
_____ Tics/twitches	_____ Impulsiveness	_____ Lack of self-control
_____ Over-activity	_____ Unhappiness	_____ Does not want to come to school

Does this child have a history of:

_____ alcohol use	_____ drug use	_____ running away from home
_____ stealing	_____ setting fires	_____ vandalism
_____ threatening others	_____ gang involvement	_____ fighting
_____ cruelty to animals	_____ bullying	_____ being bullied

What is this child's bedtime: weekdays? _____ weekends? _____

How long does this child generally sleep? _____ Does this child have difficulty sleeping? _____

Explain _____

Has this child ever undergone psychological or psychiatric evaluation? _____ Date(s) of exam(s): _____

By Whom? _____ Reason(s): _____

_____

Has this child ever received counseling or therapy? _____ From whom? _____

Reason(s): _____

Is this child currently receiving counseling or therapy? _____ From whom? _____

Reason(s):_____

Has this child ever received speech/language therapy, occupational therapy, and/or physical therapy services? _____

When?_____ Where?_____

Additional Information/Comments

Use the space below to expand upon your previous responses or to provide information that you have not previously provided but you feel is important in helping us understand your child. Please sign and date this form below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I understand that the Tier III/ Student Support Team (SST) will meet to develop alternative strategies and interventions for my child. I ☐ give ☐ do not give consent (check one) for the Oconee County School System to perform vision and hearing screenings. I also give consent for individually administered assessments with my child to assist with progress monitoring of interventions.

Signature: _____ Date: _____

Dr. Jason L. Branch, Superintendent

OCONEE COUNTY SCHOOLS
34 SCHOOL STREET, P.O. BOX 146
WATKINSVILLE, GA 30677
(706) 769-5130
(706) 769-3500 FAX

Hearing and Vision Screening Form

_____ at _____
(Student Name) **(School Attending)**

was administered a Hearing and Vision screening test with the following results:

HEARING: (500, 1,000, 2,000, 4,000 Hz at 25 dB for each ear)

DATE: _____ **Pass** _____

Did Not Pass _____

_____
(Examiner)

VISION: (20/40 acuity for each eye)

DATE: _____ **Pass** _____

Did Not Pass _____

_____
(Examiner)

Revised 7/28/16

Oconee County Schools

Enrolling School _____ STUDENT INFORMATION/ENROLLMENT SHEET Locker # _____
School Year _____ Teacher _____

Demographics

Student Name _____ Grade _____ Male Female (Circle One)
Last First Middle

Street Address _____ Mailing Address _____
City _____ St ____ Zip _____ City _____ St ____ Zip _____
Home Phone _____ Previous Address _____
City _____ St ____ Zip _____
Student's Social Security Number _____ Date of Birth _____

***A parent/guardian who objects to incorporation of the social security number into the school records of a child may have the requirement waived by signing the STATEMENT OF OBJECTION TO THE USE OF SOCIAL SECURITY NUMBER FOR STUDENT IDENTIFICATION. Please be advised that in doing so, it may impact HOPE Scholarship/Grant Eligibility in the future.**

Father's Name _____ Mother's Name _____
Father's Day Phone _____ Mother's Day Phone _____
Father's Employer _____ Mother's Employer _____
Father's Home Phone _____ Mother's Home Phone _____
Father's Cell Phone _____ Mother's Cell Phone _____
Father's E-mail _____ Mother's E-mail _____

Does student reside with both parents? Yes ___ No ___
If "No," with whom does student reside? _____ Relationship _____
Are both persons named above the student's legal guardian(s)? _____ (Documentation may be requested.)
***The child must reside with the ENROLLING ADULT.**

Ethnicity – Is the student of Hispanic/Latino ethnicity? Yes _____ No _____ **(Must also indicate race.)**

Sibling(s)	Age(s)	School(s)

Race (check **all** that apply)
____ Black/African American
____ American Indian/ Alaska Native
____ Asian
____ Native Hawaiian/Other Pacific Islander
____ White

Parent/Guardian Alert

If there are any special restrictions regarding your student's pickup, please explain. _____
_____

Emergency Contacts/Medical

May either parent be contacted in case of an emergency? Yes ____ No ____ (If "No," please explain.) _____
_____

Whom do we contact if parent or guardian is unavailable? By listing these contacts, you are hereby authorizing them to check your student out of school and to be responsible for your child's welfare and transportation from school.

Contact (Last/First) _____ Phone (No./Type) _____ Relationship _____
Contact (Last/First) _____ Phone (No./Type) _____ Relationship _____
Contact (Last/First) _____ Phone (No./Type) _____ Relationship _____

Doctor _____ Phone _____ Allergies _____
Medical Alert _____

In case of illness/injury, the school will render first aid as directed by OCS policy and procedures. If the situation is very serious, the school shall telephone Oconee County Medical Emergency (911) for immediate transportation to an emergency treatment hospital. Fees for transportation and medical services will be the responsibility of the parent/guardian.

Do you have insurance for your Child? Yes _____ No _____
If not, and you qualify, would you be interested in receiving information regarding Peach Care for kids? Yes ____ No ____

Military

Is parent or guardian on active duty in the US Armed Forces, including National Guard or Reserve Forces? Yes ____ No ____
Is parent or guardian a member of the military reserves in the US Armed Forces, National guard or Reserve? Yes ____ No ____

(continued on back)

Transportation AM To School: Car _____ ☐ M ☐ Tu ☐ W ☐ Th ☐ F
Bus _____ ☐ M ☐ Tu ☐ W ☐ Th ☐ F Route # _____

Transportation PM From School: Car _____ ☐ M ☐ Tu ☐ W ☐ Th ☐ F
Bus _____ ☐ M ☐ Tu ☐ W ☐ Th ☐ F Route # _____
Daycare _____ ☐ M ☐ Tu ☐ W ☐ Th ☐ F Daycare Name _____ Phone _____

If high school student, does student drive his/her own vehicle? Yes _____ No _____ Parking space # _____

Weather or other emergencies could cause schools to dismiss early. Because it may be difficult to make or receive phone calls, schools cannot rely on last minute communication. Please designate BELOW how you would like your child to go home in the case of an unforeseen event.

_____ Ride regular bus home
_____ Ride bus to another home: Name _____ Address _____
_____ Daycare (YMCA, YWCO, & OCPRD will typically be closed.)
_____ Car rider
_____ Other (please explain) _____

State Specific
City of Birth _____
State of Birth _____
Country of Birth _____
If born outside the U.S., entry date to U.S. schools _____

List any U.S. school(s) attended in the past three years (if applicable).

School Name	State	Dates Attended
_____	____	_____
_____	____	_____
_____	____	_____

Home Language Survey – This survey assists school personnel in deciding whether your child may be a candidate for additional English language support. *Student will be assessed for ESOL for any answer other than English.

1. Which language does your child best understand and speak? _____
2. Which language does your child most frequently speak at home? _____
3. Which language do adults in your home most frequently use when speaking with your child? _____
4. In which language would you prefer to receive all school communication? _____

Name of Pre-K that the student attended _____
Please check one:

_____ Early Head Start _____ Blended Head Start/GA Pre-K _____ Head Start 3 _____ Head Start 4
_____ Head Start 5 _____ Title 1 Funded Pre-K _____ GA Lottery Funded Pre-K
_____ Spec. Ed. 3-Year Olds _____ Spec. Ed. 4-Year Olds _____ Other Pre-K _____ Did Not Attend

Transferring from outside Oconee County Schools
To the best of your knowledge, does your child receive any of the following services:

Special Education: Yes _____ No _____ ESOL Services: Yes _____ No _____
Gifted Services: Yes _____ No _____ EIP Services: Yes _____ No _____
Section 504 Services: Yes _____ No _____

Picture Publications
In order to celebrate school events, OCS may publish pictures of classes, teachers, and students in the local newspapers, school district publications, and/or on our website. Student pictures that appear on the Internet will not be identified by name. Pictures that appear in the newspapers or school district publications may contain students' names.

_____ I would NOT like for my child's picture to be published in the local newspapers or school district publications.
_____ I would NOT like for my child's picture to appear on the school website.
_____ I APPROVE of my child's picture being published in local newspapers, school district publications, and/or on the school website.

Who is the enrolling adult? (circle one) Father/Guardian Mother/Guardian Both

***A student can only be withdrawn by the person who enrolls them.**

SIGNATURE OF ADULT ENROLLING THE CHILD

Father/Guardian Signature	**Father/Guardian Printed Name**	**Date**
Mother/Guardian Signature	**Mother/Guardian Printed Name**	**Date**

REGULAR EDUCATION DOCUMENTATION OF INTERVENTIONS
(PRESCHOOL – 12TH GRADE)

The referring agency must document a history of failed classroom interventions and/or programs which, however appropriate, proved ineffective, before referring a student for special education evaluation. (MUST document at least 4 research-based interventions that were implemented for a minimum of 12 weeks)

Student: _____ Teacher: _____ Grade: _____

Description of problem(s): _____

_____

_____

Intervention	Date Begun	Date Evaluated	Data/Comments

CONFIDENTIAL
OBSERVATION FORM

Name: _____ Grade: _____ Age: _____

Date: _____ Time: _____

Observer: _____ Class Observed _____

1. Classroom activity:

2. Description of student:

3. Student's physical location in the room:

4. Activity level – (wiggles, stretches, yawns, taps foot):

5. Facial expressions:

6. Level of distractibility:

7. Interaction with peers:

8. Interaction with teachers:

9. How well did the student shift from one activity to another?

10. How did student work best (alone, free time, timed)?

11. What does student do during free times?

12. Atmosphere of classroom (physical and emotional):

13. Please comment on observed limitations to classroom/academic participation, if any:

Oconee County School System
TIER III

SAMPLES OF ANALYZED WORK

NOTE: Samples of student work relevant to the Tier III referral should be analyzed and attached to this completed form.

Student _____ Date _____

Grade _____ Teacher _____ Subject _____

1. What was the assignment? Is this work new to the student? Review?

2. What errors were made?

3. How did the student complete the assignment (e.g., last to start, jumped in before directions were given, copied work of others, etc.)?

4. How does this student's work on this assignment compare to the work of others in the class?

5. Is this sample typical of this student's work? (Explain)

6. What other comments about this student do you feel would be beneficial to make?

Oconee County School System
Pyramid of Interventions

To whom it may concern:

The attached forms must be completed and returned with the referral information. The forms that need to be completed are dependent upon the referring problem. They reflect interventions that have been identified as being research-based. They are presented in a checklist format, with space for documentation of results of the intervention. These results should be expressed in measurable terms (i.e. correct words per minute, math quiz scores, number of times redirected to task).

1) Reading Referrals will require completion of:
"Regular Education Documentation of Readings Interventions"

2) Math Referrals will require completion of:
"Regular Education Documentation of Mat Interventions"

3) Behavior Referrals will require completion of:
"Regular Education Documentation of Behavioral Interventions"

4) Problems other than Reading, Math, or Behavior will require completion of:
"Regular Education Documentation of Interventions"

REGULAR EDUCATION DOCUMENTATION OF INTERVENTIONS
(PRESCHOOL – 12TH GRADE)

The referring agency must document a history of failed classroom interventions and/or programs which, however appropriate, proved ineffective, before referring a student for special education evaluation. **(MUST document at least 4 research-based interventions that were implemented for a minimum of 12 weeks)**

Student: _____ Teacher: _____ Grade: _____

Description of problem(s): _____

_____

_____

Intervention	Date Begun	Date Evaluated	Data/Comments

Name _____ DOB _____ Grade _____ Teacher _____

Parents were notified of concern on: **Notification Date** _____ **By** _____

● If primary language is other than English, attach complete English language proficiency document. (Proficiency or Native Language was assessed and found adequate before referral.)

Areas of Concern (check all that apply): Student must be assessed in each area related to suspected disability.

Academic	**Physical**	**Social/Emotional**	**Communication**
__Reading	__Hearing	__Aggressive	__Articulation/Speech
__Math	__Vision	__Withdrawn	__Oral Language
__Spelling	__Fine Motor	__Peer Relationships	__Fluency/Stuttering
__Writing	__Gross Motor	__Self Image	__Voice
__Following directions	__Hyperactivity	__Discipline	__Listening Skills
__Study Skills	__Hypoactivity	__Acting Out	__Other_____
__Attention Span	__Self-Help/Adaptive	__Attention	
__Other _____	__Physical Handicaps	__Task Completion	
__Other_____	__Other_____	__Other_____	

State Problem(s) in SPECIFIC, OBSERVABLE, MEASUREABLE TERMS (i.e. Student reads 10 words per minute with 55% accuracy, student completes 1 or 5 assignments daily, students recognizes 3 letters, etc.)

_____

_____

_____

_____

Other Information:

Prior Schools Attended _____ Dates/Grades Attended _____

Prior Schools Attended _____ Dates/Grades Attended _____

Prior Schools Attended _____ Dates/Grades Attended _____

Name of Test _____ Results _____

Name of Test _____ Results _____

Name of Test _____ Results _____

Has this student ever received special education? ___Yes ___No If Yes, when _____

Has student ever been retained? ___Yes ___No If Yes, when _____

Date of Vision Screening _____ ___Passed ___Fail Action _____

Date of Hearing Screening _____ ___Passed ___Fail Action _____

Attendance _____Problem _____No Problem Comments _____

Health _____Problem _____No Problem Comments _____

Other relevant information: _____

REGULAR EDUCATION DOCUMENTATION OF READING INTERVENTIONS
(KINDERGARTEN – 12TH GRADE)

The private agency must document a history of failed classroom interventions and/or programs which, however appropriate, proved ineffective, before referring a student for special education evaluation. **(MUST document at least 4 research-based interventions that were implemented for a minimum of 12 weeks and date that interventions and/or programs failed.)**

Student: _____ Teacher: _____ Grade: _____

READING INTERVENTIONS Daily whole group reading instruction in:	DATE BEGUN	DATE ENDED	COMMENTS/DATA
Phonological awareness Activities (K)			
-Identify and make oral rhymes			
-Segment spoken sentences into words			
-Segment spoken words into syllables			
-Identify and practice onset and rhyme sounds			
-Identify spoken words w/same initial sounds			
-Identify spoken words w/same end sounds			
-Blend orally presented phonemes into words			
-Segment orally presented word into phonemes			
Phonics Activities (K-2)			
-Match letters/sounds (initial and final letters)			
-Blend sounds to read real and nonsense words			
-Read aloud charts, stories, CVC, CVCe, blends, words families, diphthongs, etc.			
-Dictate words w/featured letter/sound pair			
-Pair students for practice reading aloud			
-Recognize print patterns-chunks, ending, etc.			
Fluency (Grades 2-3)			
-Model fluent reading			
-Repeated reading of same text (3-4 times)			
-Choral reading			
-Echo reading			
-Shared reading			
-Text at independent reading level (95% accuracy)			
Vocabulary (K-1)			
-Sort words into basic categories			
-Describe common objects.			
-Classify categories of words			
Vocabulary (Grades 2-3)			
-Teach common synonyms and antonyms			
-Use known word in compound words			
-Teach homophones/homographs			
-Use dictionary to locate word meanings			
Vocabulary (Grades 4-5)			
-Identify/apply knowledge of word origins, derivations, synonyms, etc. to derive meaning			
-Use a thesaurus to identify related words			
Reading Comprehension (All Grades)			
-Teach to self-monitor comprehension			
-Teach use of graphic/semantic organizers			
-Teach use of questions to guide reading			
-Teach ways to generate questions			
-Teach story structure			
-Teach summarization			
-Elaboration (prediction, prior knowledge, etc.)			
Other			

REGULAR EDUCATION DOCUMENTATION OF MATH INTERVENTIONS
(KINDERGARTEN – 12TH GRADE)

The private agency must document a history of failed classroom interventions and/or programs which, however appropriate, proved ineffective, before referring a student for special education evaluation. **(MUST document at least 4 research-based interventions that were implemented for a minimum of 12 weeks and date that interventions and/or programs failed.)**

Student: _____ Teacher: _____ Grade: _____

MATH INTERVENTIONS If child is having difficulty because:	DATE BEGUN	DATE ENDED	COMMENTS/DATA
Overall Skills Are Lower Than Grade Level			
-Assess for level of instruction			
-Provide small group instruction on needed skills			
Difficulty Remembering Math Facts			
-Separate facts into sets or fact families			
-Provide extra opportunities for practice			
-Provide references to assist in fact calculation			
-Use manipulative objects			
-Practice flashcards with peer/volunteer			
-Use folding in technique for flashcard practice			
-Student self-check/correct practice sheets			
Difficulty Attending To Important Details			
-Highlight operational signs/key words			
-Use vertical lines/graph paper for organization			
-Reduce number of problems per page			
-Use a window overlay to isolate problems			
-Have student repeat directions to teacher			
Inability To Read Text For Word Problems			
-Align material with students reading level			
-Highlight key words in math problem			
Slow Rate Of Work Completion			
-Reduce number of items to complete			
-Provide Manipulatives			
Problems Sequencing Steps For Computations			
-Consistent review of steps			
-Reference sheet kept at student desk			
-Use of acronyms to remember steps			
-Color coding of steps			
-Use of manipulative objects			
-Use of calculator			
Failure To Visualize concepts			
-Use simple, consistent language			
-Provide visual examples			
-Assess and explicitly teach concept terminology			
Difficulty Solving Word Problems			
-Use concrete examples			
-Highlight key operational words			
-Have student restate problem			
-Use of calculator/manipulatives			
Other			
-Peer tutoring			
-Small group instruction			
-Individual assistance from teacher/volunteer			

REGULAR EDUCATION DOCUMENTATION OF BEHAVIORAL INTERVENTIONS (KINDERGARTEN – 12TH GRADE)

The private agency must document a history of failed classroom interventions and/or programs which, however appropriate, proved ineffective, before referring a student for special education evaluation. **(MUST document at least 4 research-based interventions that were implemented for a minimum of 12 weeks and date that interventions and/or programs failed.)**

Student: _____ Teacher: _____ Grade: _____

BEHAVIORAL INTERVENTIONS	DATE BEGUN	DATE ENDED	COMMENTS/DATA
If problem is inappropriate behavior			
-Post classroom rules			
-Model desired behaviors			
-Verbal/nonverbal reminders of behavior			
-Provide choices			
-Positive attention to others who are modeling appropriate Behavior			
-Positive reinforcement of appropriate behavior			
-Remind student of expected behavior			
-Daily/weekly behavior report home			
-Positive notes home			
Proximity control			
-Loss of privileges			
-In class isolation			
-Time out			
-Use of logical/natural consequences			
-Parent conference			
-Interaction w/school counselor			
-Change class routine			
-Discipline contract			
-Seating change			
-Extra teacher attention			
-Curriculum change			
-Schedule change			
If problem is off-task behavior/work completion			
-Preferential seating (away from distractions)			
-Use of study carrel			
-Seat near well-focused students			
-Have student repeat directions to teacher			
-Assess instructional level/adapt curriculum			
-Reduce/modify assignment			
-Placement change within regular education			
-Daily effort report			
-Weekly effort report			
-Use assignment book (parent & teacher sign)			
-Use timer for self-monitoring of task complete			
-Provide "to do" list for student's desk			
-Break task into smaller chunks			
-Reward system for task completion			
Other			
-Individual/small group instruction			
-Small group instruction			
-Use multi-sensory learning approaches			
-Provide routine schedule			

TEACHER INTERVENTION/STRATEGIES
(LANGUAGE)

The following are interventions or strategies that can be used in the classroom. These should be implemented for a total of four weeks (including the two-week observational period).

INTERVENTION/STRATEGIES:

1. When the student says something incorrectly, repeat it in a natural way. For example, if the child says, "I goed to the store." You'd say, "Oh, you went to the store".
2. When introducing new words, pair the word with a picture, or try to relate the word to a personal experience. Keep words visible in the classroom.
3. Establish good eye contact before giving directions/instructions, rephrase, or have the student repeat the directions before beginning.
4. Provide adequate time for the child to process what you have asked and for them to form their answers. Example, "Be thinking about _____ while I collect the papers."

DATES FROM/TO	INTERVENTION/STRATEGIES	RESULTS

- Attach additional interventions and/or work samples (demonstrating errors).

_____ _____

Signature of Teacher Date

TEACHER INTERVENTIONS/STRATEGIES (ARTICULATION)

The following are interventions or strategies that can be used in the classroom. These should be implemented for a total of four weeks (including the two-week observational period).

INTERVENTION/STRATEGIES:

1. Model (with some exaggeration) correct production of sounds(s) for student when applicable. See if student can produce the sound in isolation (by itself, not in a word). For example, when a student says "wabbit," teacher responds "Oh, you mean rrrrrrrrabbit." Encourage imitation by the student.
2. Provide visual cue for sound correction in oral language (write what student has said with errors, then write the correct form). For example, If a student says "wabbit," write down "wabbit" for them, then show them how it is correctly spelled and spoken.
3. Provide visual cue for sound correction in written language (if student is making spelling errors in writing due to articulation). For example, if a child misspells a word, simply write the correct form when correcting it.
4. Auditory bombardment: read stories that emphasize target sounds that the student is having difficulty with. For example, read Stone Soup in class with emphasis on the /s/ sounds, if your student has a lisp.

DATES FROM/TO	INTERVENTION/STRATEGIES	RESULTS

- Attach additional interventions and/or work samples (demonstrating spelling errors).

Signature of Teacher

Date