

Suwannee County Public Schools
Student Services Division
702 Second Street NW
Live Oak, FL 32064
(386) 647-4630

TEACHER INPUT

Date: _____

Form completed by: _____

Student Name	Grade	DOB	School Name

Parent/Guardian:	
Address:	
Phone:	
Email Address:	

Presenting Problem(s): Academic Behavioral

Please describe specific concerns. List any academic, social, or emotional factors the negatively impact the student's performance.

In what settings/situations does the problem occur *most* often?

In what settings/situations does the problem occur *least* often?

What are the student's, strengths, talents or special interests?

Attach copies of the following required information:

- Current report card
- Progress report(s)
- Student schedule (secondary)/classroom schedule (elementary)
- Discipline record (if applicable)
- Attendance record
- Documentation of interventions
- Record review form
- Meeting summary sheet/Parent conference documentation
- All pertinent data (including progress monitoring information)

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OBSERVATIONS

(Observations **must** be conducted during the time when the student's learning or behavioral areas of concern occur)

Observation Date: _____

Student Name	Grade	DOB	School Name

OBSERVATION SUMMARY: Pre-intervention Observation Post-intervention Observation

Observer / Position: _____ Start Time: _____ End Time: _____

Subject Area: _____

Class Activity: Teacher directed whole class Teacher directed small group Independent work session
 Other (describe): _____

Directions: Place a (X) beside the problem behaviors that were observed **during this observation**.

	ACADEMIC ENGAGEMENT		ATTENTION/ORGANIZATION		SOCIAL/BEHAVIORAL
<input type="checkbox"/>	Difficulty beginning / completing tasks	<input type="checkbox"/>	Does not follow classroom rules	<input type="checkbox"/>	Needs constant reassurance
<input type="checkbox"/>	Gives up easily	<input type="checkbox"/>	Does not comply to teacher direction	<input type="checkbox"/>	Cries/pouts/sulks
<input type="checkbox"/>	Reverses/confuses letters, words, numbers	<input type="checkbox"/>	Talks out excessively	<input type="checkbox"/>	Acts frightened; timid/shy
<input type="checkbox"/>	Does not participate in discussion/activity	<input type="checkbox"/>	Disorganized desk and work materials	<input type="checkbox"/>	Withdrawn
<input type="checkbox"/>	Does not turn in assignments	<input type="checkbox"/>	Difficulty transitioning between tasks	<input type="checkbox"/>	Avoided or rejected by peers
<input type="checkbox"/>	Requires teacher prompting to work	<input type="checkbox"/>	Short attention span	<input type="checkbox"/>	Clings to teachers or others
<input type="checkbox"/>	Excessively seeks others' assistance	<input type="checkbox"/>	Fidgets with objects	<input type="checkbox"/>	Nervous/excitable
<input type="checkbox"/>	Does not ask for assistance	<input type="checkbox"/>	Stares blankly/seemingly daydreams	<input type="checkbox"/>	Argumentative
<input type="checkbox"/>	Out of seat or assigned work area	<input type="checkbox"/>	Acts impulsively	<input type="checkbox"/>	Loses temper
	LANGUAGE ARTICULATION		PHYSICAL CONCERNS	<input type="checkbox"/>	Picks on others
				<input type="checkbox"/>	Physically aggressive toward others
<input type="checkbox"/>	Difficulty understanding written directions	<input type="checkbox"/>	Seems tired/lethargic	<input type="checkbox"/>	Swears/ uses profanity
<input type="checkbox"/>	Difficulty understanding oral directions	<input type="checkbox"/>	Makes physical complaints	<input type="checkbox"/>	Changes mood rapidly
<input type="checkbox"/>	Difficulty understanding student's speech	<input type="checkbox"/>	Poor fine motor coordination	<input type="checkbox"/>	Talks disrespectfully to others
<input type="checkbox"/>	Difficulty answering question's verbally	<input type="checkbox"/>	Poor gross motor coordination	<input type="checkbox"/>	Damages property
<input type="checkbox"/>	Poor use of grammar/vocabulary	<input type="checkbox"/>	Fidgets/squirms	<input type="checkbox"/>	Disrupts activities/learning environment

NARRATIVE OF OBSERVATION:

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**GENERAL EDUCATION
 FUNCTIONAL BEHAVIOR ASSESMENT (FBA)**

Initiation Date: _____

Student Name	Grade	DOB	School Name

Describe behavior in observable and measurable terms:			
Baseline Data			
Intervention results:			
Identify places in which the behavior occurs:	<input type="checkbox"/> classroom <input type="checkbox"/> cafeteria <input type="checkbox"/> library	<input type="checkbox"/> hallway <input type="checkbox"/> office <input type="checkbox"/> guidance office	<input type="checkbox"/> gym <input type="checkbox"/> school bus <input type="checkbox"/> bus loading area <input type="checkbox"/> school grounds <input type="checkbox"/> home <input type="checkbox"/> other: _____
Identify times at which the behavior occurs:	<input type="checkbox"/> large group <input type="checkbox"/> small group	<input type="checkbox"/> instructional time <input type="checkbox"/> non-instructional time	<input type="checkbox"/> specific academic demand <input type="checkbox"/> verbal directive <input type="checkbox"/> transitional time <input type="checkbox"/> other: _____
Identify people with whom the behavior occurs:	<input type="checkbox"/> peer(s) <input type="checkbox"/> teacher(s)	<input type="checkbox"/> administrator(s) <input type="checkbox"/> school counselor(s)	<input type="checkbox"/> parent <input type="checkbox"/> other: _____
Frequency of the behavior: <input type="checkbox"/> hourly <input type="checkbox"/> daily <input type="checkbox"/> other: _____	Duration of the behavior: <input type="checkbox"/> less than 15 minutes <input type="checkbox"/> 15 -30 minutes <input type="checkbox"/> more than 30 minutes	Intensity of the behavior: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe	
Antecedent events (Describe circumstances that occur immediately <i>prior</i> to the target behavior):			
Consequent events (Describe circumstances that occur immediately <i>after</i> the target behavior):			
Functional Assessment Methods			
Areas Assessed:	Refer to:	Date(s):	
Environmental and Social Factors	Record review		
Parent Input	Parent Conference / Meeting Summary		
	SST Meeting Minutes		
Description of Previous Interventions	Documentation of Interventions		
Observations	Observation(s)		
Students Strengths and Weaknesses	Teacher Input		
Functional Hypothesis			
When this occurs.....	The student does.....	To get or to avoid.....	
FBA Team Members	Refer to SST Meeting Minutes Date: _____		

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ACADEMIC INTERVENTION PLAN

Design Date: _____

Intervention Implementation Date: _____

Student Name	Grade	DOB	School Name

Baseline data of target skill:	
Short-term Goal (next 4-6 weeks):	
Long-term Goal:	

Intervention Design (describe specific activities implemented):

WHO: Who is responsible for implementing this intervention plan?	
WHAT: What strategies will you use to increase the desired academic skill?	
WHERE: In what setting will the intervention be implemented?	
WHEN: At what time and how often will the intervention be implemented?	

Progress Monitoring Method (Describe type of monitoring tool, charting system, etc., to be used)	
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Progress Review Date #1:	Intervention Results:
Progress Review Date #2:	Intervention Results:

Tier 3 Academic Intervention and Progress Monitoring Log

Student Name: _____ Grade Level: _____ Teacher: _____

School Year: _____ School: _____ Interventionist: _____

Targeted Skill Deficit: _____ Source: _____

Intervention: _____ Frequency: __ Mins __ Days Per Week Ind. Sm. Group

Progress Monitoring Tool: _____ Data: % Correct WCPM # Errors Other _____

Week of:	Intervention Delivered	Student	Peer/Group Average	Expectation	Comments/Notes
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
PROGRESS MONITORING					
Week of:					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
PROGRESS MONITORING					
Week of:					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
PROGRESS MONITORING					
Week of:					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
PROGRESS MONITORING					
Week of:					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
PROGRESS MONITORING					

Teacher = Classroom Teacher

Interventionist = Teacher delivering intervention (Tier 3 intervention must be teacher-led)

Targeted Skill Deficit = specific skill (e.g., decoding, fluency, 2-digit subtraction, word attack on multi-syllabic words, sight-word vocabulary on high frequency words). Target the foundational, core skill deficit.

Targeted Skill Deficit Source = e.g., iReady, DAR, Omni, STAR, iExcel

Intervention = e.g., Program/curriculum, Strategy (re)taught, Teaching method (Intervention must directly address skill deficit)

Progress Monitoring Tool = Specific assessment used to measure progress (response to intervention) on the targeted skill deficit. Examples: letter-sound flashcards, running record, ORF, pseudoword list (decoding), sight word flashcards, math problem worksheet, may be a teacher-designed or curriculum-based measure. Tool should be on the student's instructional level (not grade level).

Data = Type of score produced by Progress Monitoring Tool (circle one or write-in)

Completing Log:

Intervention Delivered = Interventionist *initials* to verify each day intervention was delivered AND when Progress Monitoring Tool is administered

Progress Monitoring (write in each score) Be sure to include the date of the assessment

Student = Targeted student's score on the Progress Monitoring Tool

Peer/Group Average = The average score on the Progress Monitoring Tool of all students in this student's same intervention group (this is the preferred data) OR Select a student in the intervention group who began at or near the same level of this student and report that student's score

Expectation = Report the score where this student 'should' be – on this Progress Monitoring Tool - based on school, district, state, national norms, curriculum standards/benchmarks. This score must be the same type of score provided for student and peer group. The expectation can be 80% accuracy (considered the minimum for mastery) provided the student and peer scores are also accuracy percentage.

** Must report the same type and source of data for each probe over the intervention/progress monitoring period

Intervention Documentation Worksheet

Week of: _____

Teacher: _____

Student Name	Monday			Tuesday			Wednesday			Thursday			Friday			Total of Minutes
	T	P	F	T	P	F	T	P	F	T	P	F	T	P	F	

Legend

<p>T = Time (# of minutes)</p> <p>P = Program</p> <p>F = Focus</p>	<p>Focus</p> <p>L = Language</p> <p>PA = Phonemic Academics</p> <p>P = Phonics</p> <p>F = Fluency</p> <p>V = Vocabulary</p> <p>C = Comprehension</p>	<p>Program</p> <p>Create your own key. For example:</p> <p>W=Wilson Foundations</p> <p>_____ = _____</p> <p>_____ = _____</p> <p>_____ = _____</p>
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**Suwannee County School District
Office of Student Services
Documentation of Pre-Referral Activities for ESE Referral**

Student Name	Grade	DOB	School Name

Teacher: _____

Concerns:

Academic Speech Language
 Emotional / Behavioral Gifted

Previous Referral or Evaluation: Yes No Date: _____

Parent Conference Dates: (1) _____ (2) _____
(Any meetings attended by parent)

Social-Developmental History: Date: _____
(This is for suspected Intellectual or Emotional /Behavioral Disabilities only)

Intervention Document Worksheet attached: Yes No
(Referral will not be processed without this attachment)

Behavioral Observation Dates: (1) _____ (2) _____
("Speech only" referrals need classroom checklist. Gifted requires no observation. ALL others MUST include at least one observation completed/dated AFTER consent for evaluation is signed.)

SST Meeting Dates: (1) _____ (2) _____
 (3) _____ (4) _____
(Gifted only needs one meeting. "Speech only" does not require SST.)

Sensory Screenings: (5200-006) Consent must be signed by parent prior to screenings.
 Screening consent date: _____

(1) Vision Date _____ Pass Fail (3) Speech Date _____ Pass Fail
 (2) Hearing Date _____ Pass Fail (4) Language Date _____ Pass Fail

***For Emotional/Behavioral referrals only, include FBA/BIP.** Date of BIP _____.

Parent Consent to Evaluate (5200-011) Date signed: _____
(Referral MUST be received at Student Services office within 10 days of signed consent.)

SUWANNEE COUNTY SCHOOL DISTRICT

Sensory Screening Form

Student Name	Grade	DOB	School Name

Referred By: _____

Teacher: _____

Parent Consent: _____ Date: _____

<p style="text-align: center;">HEARING</p> <p style="text-align: center;">Passed: <input type="checkbox"/> Failed: <input type="checkbox"/></p> <p>Comments:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div> <p>_____ Person Responsible/Position Further Evaluation Required: Yes <input type="checkbox"/> No <input type="checkbox"/> Date of Evaluation _____</p>	<p style="text-align: center;">VISION</p> <p style="text-align: center;">Passed: <input type="checkbox"/> Failed: <input type="checkbox"/></p> <p>Comments:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div> <p>_____ Person Responsible/Position Further Evaluation Required: Yes <input type="checkbox"/> No <input type="checkbox"/> Date of Evaluation _____</p>
<p style="text-align: center;">SPEECH</p> <p style="text-align: center;">Passed: <input type="checkbox"/> Failed: <input type="checkbox"/></p> <p>Comments:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div> <p>_____ Person Responsible/Position Further Evaluation Required: Yes <input type="checkbox"/> No <input type="checkbox"/> Date of Evaluation _____</p>	<p style="text-align: center;">LANGUAGE</p> <p style="text-align: center;">Passed: <input type="checkbox"/> Failed: <input type="checkbox"/></p> <p>Comments:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div> <p>_____ Person Responsible/Position Further Evaluation Required: Yes <input type="checkbox"/> No <input type="checkbox"/> Date of Evaluation _____</p>