

**GENERAL EDUCATION INTERVENTION**

Student Name: \_\_\_\_\_ District: \_\_\_\_\_ School: \_\_\_\_\_

Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Parent(s): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_ Date: \_\_\_\_\_

Retentions: \_\_\_\_\_ Grade: \_\_\_\_\_ Number of Schools Attended: \_\_\_\_\_

Attendance History (Past/Current): \_\_\_\_\_

Hearing Screening Date: \_\_\_\_\_ Results: \_\_\_\_\_

Vision Screening Date: \_\_\_\_\_ Results: \_\_\_\_\_

List significant physical/medical information (i.e., seizures, allergies, medication, etc.): \_\_\_\_\_

\_\_\_\_\_

Have there been any major changes at home which might effect this student? \_\_\_\_\_

\_\_\_\_\_

**Intelligence Data:** List group and/or individual scores for the last three years: **SCORE** **DATE**

Assessment: \_\_\_\_\_

Assessment: \_\_\_\_\_

Assessment: \_\_\_\_\_

**Achievement Data:** List the last three years results or more if much variability

Date Test Results

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Informal Test Data (including observations):**

Date Test Results

\_\_\_\_\_

\_\_\_\_\_

**Student Strengths:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What specific skills must the student possess to successfully function: (1) in your classroom; (2) age appropriately and/or at the current development age level; (3) at potential?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Areas of Concern:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b><u>Additional Documentation Requested:</u></b>	<b>Person Responsible</b>	<b>Date Completed</b>
Parent Case History Summary	_____	_____
Behavior Intervention Checklist	_____	_____
Academic Intervention Checklist	_____	_____
Speech/Language Checklist	_____	_____
Motor Skill Therapy Checklist	_____	_____
Family Needs Checklist	_____	_____
Medical History Summary	_____	_____
Other	_____	_____

**Additional Comments**

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**HEALTH ASSESSMENT**

	<b>Good</b>	<b>Problem</b>	<b>Comments</b>
General Health			
Vision			
Far Point			
Near Point			
Eye Coordination			
Hearing			
Oral			
Nutrition			
Height			
Weight			
Eating Habits (Optional)			
Hemoglobin (Optional)			
Neurological Screening			
Cerebral Functions			
Cranial Nerves			
Cerebellar Functions			
Motor Systems			
Gross			
Fine			
Perceptual			
Sensory System			
Reflex Action			
Medication (list all medication currently prescribed and possible side effects.)			

OTHER: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

The **federal/state mandate** requires there is documentation in the student's file describing the intervention strategies attempted by the general education teacher and the corresponding effects on student performance and progress. Has this information been included? (for example see pages 3 and 4 of this document).

\_\_\_\_\_Yes                      \_\_\_\_\_No                      \_\_\_\_\_Not Applicable

Considering the **intervention strategies implemented**, have all applicable interventions been clearly attempted prior to referring the student for assessment? (see team worksheet page 3 of 4).

\_\_\_\_\_Not at all      \_\_\_\_\_Some      \_\_\_\_\_Most      \_\_\_\_\_All      \_\_\_\_\_N/A

**General Education Team Recommendation:**

\_\_\_\_\_ Refer to Special Services                      Referral Staffing Date: \_\_\_\_\_

\_\_\_\_\_ No Special Services Indicated                      Team Follow-Up Date: \_\_\_\_\_

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The parent has been contacted and been invited to participate.** \_\_\_\_\_ Yes      \_\_\_\_\_ No \_\_\_\_\_

By: Letter \_\_\_\_\_ &/or Phone \_\_\_\_\_ Date \_\_\_\_\_ (Please Check and Date)

The following General Educational Team members are in agreement with the above recommendation (LCP pg. 20; K.S.A. 91-12-40(c); K.A.R. 91-12-22)

General Education Team:	Signatures	Title	Date
		Administrator/Designee	
_____	_____		
_____	_____		
_____	_____		
_____	_____		
_____	_____		
_____	_____		