SST Forms Checklist
Academic or Behavioral Concerns

Student:______________________________

- ❑ SST 1 — Student Services Team Assistance Request
- ❑ SST2 — Parent Invitation to SST Meeting
- ❑ SST2a — Parent Notification of Intervention Activities
- ❑ SST3 — Parent Consent for Screening
- ❑ SST4 — Screening Request and Report (Hearing and Vision)
- ❑ SST4a — Screening Request and Report (Speech & Language) – *Only submitted if there is a speech or language concern.*
- ❑ SST5 — Student Social/Developmental Summary (2 Pages)
- ❑ SST6 — Conference and Observation Form
- ❑ SST6a — Additional Conferences Form
- ❑ SST6b — Narrative Observation Information for Other Observer
- ❑ SST7 — RTI Summary – *Minimum of two interventions required.*
- ❑ SST8 — ESE Referral Form

In additional, the following information should also be included:

- ❑ Academic Data — Grades, FAIR, Performance Matters, STAR, FCAT Scores, and any other Pertinent academic data available.
- ❑ RTI Data — All RTI Data including graphed progress monitoring results.
- ❑ FAB — For Behaviorally Based Referrals: Functional Assessment of Behavior *The FAB must be conducted PRIOR to the implementation of interventions. The data contained in the FAB is used to develop and Monitor effective interventions.*

Once this documentation is obtained, it is sent to the School Psychologist. This person will review the file and offer feedback if there are items missing, approve the packet, or determine that the student is not recommended for evaluation. If approved, they will indicate that parent consent should be obtained. Parent consent should never be obtained prior to School Psychologist approval of the referral packet.

- ❑ SST 9 — Parent Consent for Evaluation – Obtained after Psychologist Approval.

-OR-

- ❑ SST 11 — Notice to Parents of Student Not Recommended for Evaluation

Once consent is obtained & referral is called into the district:

- ❑ SST10 — ESE Referral Data Form- *Goes to TERM Data Entry Person.*

Monroe County School District

Student Services Team

PARENT INVITATION TO STUDENT SERV:__S MEETING (SST) TEAM

Student Name:______________________________ School:______________

Teacher:______________________________ Grade:______________

Dear Parent or Guardian,

We consider you, the parent, to be a key member of the Student Services Team (**SST**), which is a school-based intervention team. Your input is important and we encourage you to participate, as much as possible, in this process. This team is comprised of administrators, teachers, and other school personnel who are involved with your child's learning. It is believed that this process will be helpful for your child.

The mission of the SST is to maximize individual student success by:

*__Identifying__ the learning needs of students who are struggling with their academics and who may be at-risk of school failure.

*__Providing__ students with academic, emotional, behavioral, and social support needed to succeed in school by implementing **Response to Intervention (RTI) & Positive Behavior Support (PBS)** strategies within the general education environment.

An SST meeting has been scheduled on:

Date:______________ Time:________________ Location:________________

Parent - **Please check one of the following and return form:**

☐ I will attend at the above date and time.

☐ I wish to attend at another date ______________ or another time ______________

☐ I am unable to attend, but please proceed without me.

If you have any questions regarding the **SST** or the school based intervention team process, please call:

______________________________ At ______________________________

SST Coordinator Phone number

____

Parent Signature Date

Check one:

______ Letter sent to parent/guardian by U.S. Mail on: ________________

______ Letter hand delivered to parent/guardian on: ________________

______ Letter sent home to parent with student on: ________________

Monroe County School District
Student Services Team

PARENT NOTIFICATION OF INTERVENTION ACTIVITIES

Student Name: ______________________________________ School: ________________
Teacher: ____________________________________ Grade: ____________________

Dear Parent or Guardian,

As per the outcome of the SST meeting on ______________, in an effort to maximize individual student success, our school's Student Services Team (SST) is suggesting the following activities for your child:

____
____
____

The mission of the school based intervention team is to***Identify** the learning needs of students who are struggling with their academics and who may be at-risk of school failure. ***Provide** students with academic, emotional, behavioral, and social support needed to succeed in school by implementing Response to Intervention (RtI) strategies and/or Positive Behavior Support (PBS) interventions within the general education classroom environment.

This team is comprised of administrators, teachers, and other school personnel who are involved with your child's learning.

The SST will collect data relevant to your child's learning and/or behavior and monitor his/her progress. The educational activities that **may be** completed as part of the SST process include, but are not limited to:

- Cumulative Record Review
- Attendance Records
- Classroom Observation
- Behavior Chart
- Anecdotal Records
- Curriculum Based/Progress Monitoring Assessments
- Development and Review of Progress Monitoring Plan
- Other: ________________________________

Comments:

NOTE: The SST will need your written permission to screen your child for Vision, Hearing, Speech and Language. Please contact the SST coordinator if you were unable to attend the above referenced team meeting.

______________________________ ______________
SST Coordinator's Name Phone

Monroe County School District
Student Services Team
PARENT CONSENT FOR SCREENING

Dear Parent of ______________________________:
(Name of student)

We are interested in your child's success in school. Therefore, your child had been referred to the school's Student Services Team (SST) to address his/her school performance. The team would like to gather more information by administering an individual screening. The screening may include vision, hearing, speech, language, social history, behavior, cognitive, observation and/or academic screening instruments.

In order for this to be accomplished, your consent for screening must be obtained. All information gathered will assist in educational planning and will be shared with you at your request.

Please check the appropriate box below below, print your name and phone number, sign and date the form.

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

___ **NO**, I do NOT give consent for my child to have an individual screening.

Comments:

Parent Name:______________________________ Phone Number: ____________

Parent Signature: ______________________________Date: ________________

Return form to the Student Services Team. If you have any questions please contact the SST Coordinator:

Name: ____________________________ Phone: ______________________

Thank You.

Monroe County School District
Student Services Team
SCREENING REQUEST AND REPORT

Student: ______________________ Date: ______________

Grade: ________ Teacher: ______________ School: ______________

Hearing

	500HZ	1000HZ	2000HZ	4000HZ
Right				
Left				

*** Audiometric screening at 25db ***

Passed:	Failed:
Comments:	
Signature of person responsible/position:	
Instrument Used:	
Date	

Further Evaluation Required/Requested? circle

YES	NO

Other Notes:

Vision

Glasses/Contact lenses

Yes ☐

No ☐

Right: ________

Left: ________

Comments:	
Signature of person responsible/position:	
Instrument Used:	
Date	

Further Evaluation Required/Requested? circle

YES	NO

Other Notes:

Monroe County School District - Student Services Team
STUDENT SOCIAL/DEVELOPMENTAL HISTORY

I. IDENTIFYING INFORMATION

Student's Name:______________________ Date of Birth: ______________________
Student's Race: ______________________ Sex: ☐ Male ☐ Female Current Age:______________
Student's Home Address: ____
Home Telephone #:____________________ Emergency Phone #:______________________

Father's Name:____________________________ Father's Age:___ Occupation:______________
Last Grade Completed in school:______________ Legal Guardian: ☐ Yes ☐ No
Address:__________________________________ Email:__________________________________

Mother's Name:____________________________ Mother's Age:___Occupation:______________
Last Grade Completed in school:______________ Legal Guardian: ☐ Yes ☐ No
Address:__________________________________ Email:__________________________________

With whom does student live? ______________ Adoptive parents ____ Foster parents______

Others In the Home: Name	Age	Relationship

Language Spoken at Home:__________ Which language does the child prefer to speak?_______

II. MEDICAL INFORMATION

Name of physician:______________________ Date of last examination:__________________
Medications student takes:____
Has the student had major illnesses and/or injuries? Explain.____________________________
Description of any hospitalization: ____
History of ear infections: ☐ Yes ☐ No / Has the child ever had ear tubes? ☐ Yes ☐ No
Medical Diagnoses (e.g. ADHD, Asthma, Autism)____

III. PREGNANCY

Check One: ☐ Full Term ☐ Premature ☐ Overdue
Describe any illness of mother during pregnancy: ____
____
Medications taken by the mother during pregnancy:
Prescribed Medications:____________________ Alcohol (how much per day): ______________
Non-prescribed medications:________________ Smoking (how many packs): ______________
Place of birth:________________________________ Baby's Birth Weight:__________________
Any complications or difficulties about the birth?______________________________________
Did the baby have any illnesses immediately after birth? ________________________________

IV. DEVELOPMENTAL HISTORY

Age sat up:________________ Age walked:______________ Age When Said First Word:________
When did toilet training begin?______________________ Age toilet trained:__________________
Any problems learning to walk or talk?____

V. BEHAVIORAL INFORMATION

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

- ☐ Sleeping:__________
- ☐ Hearing:__________
- ☐ Speech:__________
- ☐ Vision:__________
- ☐ Seizures:__________
- ☐ Bedwetting:__________
- ☐ Soiling:__________
- ☐ Temper Tantrums:__________
- ☐ High Activity Level:__________
- ☐ Prone to Accidents:__________
- ☐ Asthma:__________
- ☐ Headaches:__________
- ☐ Head Injuries:__________
- ☐ Worries:__________
- ☐ Eating Concerns:__________
- ☐ Jealousy:__________
- ☐ Nightmares:__________
- ☐ Separation Difficulties:__________
- ☐ Easily Frustrated:__________
- ☐ Allergies:__________

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

VI. FAMILY AND RELATIVES

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

- Emotional Problems:__________ Relationship:__________
- Academic Problems: __________ Relationship:__________
- Medical Problems: __________ Relationship:__________
- Physical Disabilities:__________ Relationship:__________

Were there any major life events that could have affected the child (ie, death in the family, divorce, etc.)

____

____

VII. SCHOOL HISTORY

Age Began Pre-School:__________ Age Started Kindergarten:__________

List schools attended, grades attended at each and special services the student received (occupational therapy, speech therapy, psychological evaluation, exceptional/special education, etc).

School	Grades Attended	Special Services

Has the student ever repeated a grade? ☐ Yes ☐ No If yes, what grade?__________

What are your child's strengths?__________

____

____

Is your child receiving help in any subjects (ie, tutoring after/before school)?__________

____

What kind of help do you think your child needs?__________

____

Any additional information that will assist us in understanding your child:__________

____

____

____

____

Respondent Name:__________ Signature:__________

Monroe County School District
Student Services Team

CONFERENCE AND OBSERVATION FORM

Student:______________________________ Grade: _____School: ______________________________

A. PARENT CONFERENCES: (See SST Page 6a for additional parent conferences)

Conference 1: Date______________ Participants' Names and Titles: ______________________________
____
____
____

On the following lines, please document the discussion of the student's learning or behavior areas of concern and the interventions planned.
____
____
____
____

Conference 2: Date______________ Participants' Names and Titles: ______________________________
____
____
____

Document the discussion of the student's responses to interventions and anticipated future actions.
____
____
____
____

B. OBSERVATIONS:

Please check those items frequently observed.

			Duration I have known the child	Date
1. Teacher:______________	Position______________		______	______
2. Observer:______________	Position______________		______	______

1	2		1	2	
		Poor gross motor control			Difficulty expressing ideas
		Poor fine motor control			Engages in destructive and/or aggressive behavior
		Slow to react to and follow directions			Short attention span, off-task
		Reverses or confuses letters, words, numbers			Performs inconsistently from day to day
		Frequently loses place when reading			Withdrawn
		Difficulty staying on the line when writing			Impulsive - talks out - difficulty waiting turn
		Misinterprets verbal questions and directions			Low frustration tolerance
		Appears inattentive, easily distracted			Poor judgment in social and interpersonal relations
		Poor understanding of vocabulary			Poor Memory
		Difficulty following directions in sequence			Vocal quality not appropriate, e.g. hoarse, nasal, strident pitch
		Makes inappropriate responses to conversation and questions			Difficulty understanding student's speech
		Works one grade level (or more) below in an academic subject			Cannot imitate sounds correctly
		Difficulty completing assignments			Speech not fluent, e.g. stuttering
		Leads, or joins others, in inappropriate behavior			Possible Hearing problems e.g. recurrent ear infections, tubes, allergies
		Constantly seeks attention, especially from adults			Other Speech Problems, Describe:

NOTE: Narrative Observation SST page 6b can be utilized by Observer 2

Monroe County School District

Student Services Team

NARRATIVE OBSERVATION INFORMATION FOR OTHER OBSERVER

Student Name: ______________________________ Date: __________

Class: ________________ Teacher: ____________ Grade: ______________

Observer Name: __________________ (Cannot be a peer teacher)

Time in _________ Time out _______

Situation: ☐ One to One instruction ☐ Small Group ☐ Large Class ☐ Independent

____

Narrative Observation notes:

____

____

____

____

____

____

____

____

____

____

Suggestions/Comments to SST:

Monroe County School District – Student Services Team – RTI SUMMARY

Name ______________ Teacher ______________ Grade ______ Date Completed ______________

PROBLEM IDENTIFICATION (Select ONE Per Form)

Language		Reading		Math		Behavior	
	☐ Written Expression ☐ Oral Expression ☐ Listening Comprehension ☐ Pragmatics/Social Communication		☐ Basic Reading Skills ☐ Reading Fluency ☐ Reading Comprehension		☐ Calculation ☐ Problem Solving		☐ Behavior Description ______________

Present Level of Performance (Gap Analyses, Academic Data/Comparison) ______________

Measurable Goal (acceptable grade level goal by the end of the year) ______________

ANALYSIS OF THE PROBLEM

HYPOTHESIS STATEMENT: The problem is occurring because ______________

If ______________

would occur, then the student will achieve the measureable goal (above).

INTERVENTION PLANNING

Intervention to be implemented: ______________

Start Date: ________ End Date (If ended): ________ Provided By ________ Location ________

Group Size: ______ # Days Per Week ______ Minutes Per Session ________ Materials/Support Needed: ________

Notes: ______________

ONGOING PROGRESS MONITORING

Measurement Method: ________ Collected & Graphed By: ________ Frequency: Weekly Daily Other ________*

Does it effectively measure the area of concern? Yes No / Explain ______________

Notes ______________

Reminder: results must be graphed at least weekly to effectively measure the area of concern.

INTERVENTION ANALYSIS (See Attached Graph)

Last Data Point: ________ Date: ________ Based on the *Progress Monitoring Data*, the student's response to the intervention was:

☐ POSITIVE	☐ QUESTIONABLE	☐ NEGATIVE
☐ Continue intervention(s) and progress monitoring then review progress again at next meeting. Next Meeting Date: ________ ☐ Fade the intensity of the intervention. Changes Made: ________ ☐ Refer for ESE evaluation because the intervention requires sustained & substantial effort too intense to be maintained by the general education curriculum to close the gap.*	Was intervention implemented with fidelity? ☐ Yes ☐ No *If no, use strategies to increase implementation integrity.* **If Yes, Choose one of the following:** ☐ Increase frequency and/or intensity of Intervention, continue progress monitoring, and indicate change of intervention on the graph. Days Per Week: _____ Minutes Per Session: _____ ☐ Implement a new intervention, continue progress monitoring, and indicate change of intervention on the graph (Start a new Tier Three Documentation Form). Additional data/consult/materials needed: ________ Notes: ________ Next Meeting Date: ________ ☐ Refer for ESE evaluation because the intervention requires sustained & substantial effort too intense to be maintained by the general education curriculum to close the gap.*	Was intervention implemented with fidelity? ☐ Yes ☐ No *If no, use strategies to increase implementation integrity* **If Yes, answer the following:** ☐ Yes ☐ No Was the problem identified correctly? ☐ Yes ☐ No Was the problem analyzed correctly? ☐ Yes ☐ No Was the intervention aligned with the identified problem? If *NO* to any of the above, return to the problem solving process. If *YES*, to all of the above, what additional data/info/consultation/materials are needed? ________ Next Meeting Date: ________ ☐ Refer for ESE evaluation because the intervention requires sustained & substantial effort too intense to be maintained by the general education curriculum to close the gap.* Notes: ________

***Must have attempted at least two Tier 3 interventions (each for the appropriate period of time needed to assess the student's response).**

Notes: ______________

Monroe County School District – Student Services Team – RTI SUMMARY

Name ______________ Teacher ______________ Grade ______ Date Completed ______________

PROBLEM IDENTIFICATION (Select ONE Per Form)

Language		Reading		Math		Behavior	
	☐ Written Expression ☐ Oral Expression ☐ Listening Comprehension ☐ Pragmatics/Social Communication		☐ Basic Reading Skills ☐ Reading Fluency ☐ Reading Comprehension		☐ Calculation ☐ Problem Solving		☐ Behavior Description ______________

Present Level of Performance (Gap Analyses, Academic Data/Comparison) ______________

Measurable Goal (acceptable grade level goal by the end of the year): ______________

ANALYSIS OF THE PROBLEM

HYPOTHESIS STATEMENT The problem is occurring because ______________

If ______________

would occur, then the student will achieve the measureable goal (above)

INTERVENTION PLANNING

Intervention to be implemented: ______________

Start Date ______ End Date (If ended) ______ Provided By: ______ Location: ______

Group Size ______ # Days Per Week ______ Minutes Per Session: ______ Materials/Support Needed ______

Notes ______________

ONGOING PROGRESS MONITORING

Measurement Method: ______ Collected & Graphed By: ______ Frequency: Weekly Daily Other ______*

Does it effectively measure the area of concern? Yes No / Explain ______________

Notes: ______________

Reminder: results must be graphed at least weekly to effectively measure the area of concern.

INTERVENTION ANALYSIS (See Attached Graph)

Last Data Point: ______ Date: ______ Based on the *Progress Monitoring Data*, the student's response to the intervention was:

☐ POSITIVE	☐ QUESTIONABLE	☐ NEGATIVE
☐ Continue intervention(s) and progress monitoring then review progress again at next meeting. Next Meeting Date: ______ ☐ Fade the intensity of the intervention. Changes Made: ______ ☐ Refer for ESE evaluation because the intervention requires sustained & substantial effort too intense to be maintained by the general education curriculum to close the gap.*	Was intervention implemented with fidelity? ☐ Yes ☐ No *If no, use strategies to increase implementation integrity.* **If Yes, Choose one of the following:** ☐ Increase frequency and/or intensity of Intervention, continue progress monitoring, and indicate change of intervention on the graph. Days Per Week: ____ Minutes Per Session: ____ ☐ Implement a new intervention, continue progress monitoring, and indicate change of intervention on the graph (Start a new Tier Three Documentation Form). Additional data/consult/materials needed: ______ Notes: ______ Next Meeting Date: ______ ☐ Refer for ESE evaluation because the intervention requires sustained & substantial effort too intense to be maintained by the general education curriculum to close the gap.*	Was intervention implemented with fidelity? ☐ Yes ☐ No *If no, use strategies to increase implementation integrity* **If Yes, answer the following:** ☐ Yes ☐ No Was the problem identified correctly? ☐ Yes ☐ No Was the problem analyzed correctly? ☐ Yes ☐ No Was the intervention aligned with the identified problem? If *NO* to any of the above, return to the problem solving process. If *YES*, to <u>all</u> of the above, what additional data/info/consultation/materials are needed? ______ Next Meeting Date: ______ ☐ Refer for ESE evaluation because the intervention requires sustained & substantial effort too intense to be maintained by the general education curriculum to close the gap.* Notes: ______

***Must have attempted at least two Tier 3 interventions (each for the appropriate period of time needed to assess the student's response).**

Notes: ______________

Monroe County School District
Student Services Team
ESE REFERRAL FORM

___ Behavior
___ Academic
___ Child Find/PreK
___ Gifted
___ Speech Only

Name: ______________________ Age: _____ Birth Date: ________ Student No: ____________

School: ______________________ Teacher: ______________________ Grade: _____

Referred by: ______________________ Parent's Name: ______________________

Address: ______________________________________ Phone: ____________

Free/ Reduced Lunch ? ☐ No ☐ Yes Race: ____________

ELL? ☐ No ☐ Yes CELLA Score: _____ Date: ________ Native Language: ____________

I. Briefly describe the educational area that prompted this referral:

____

____

____

II. Review of Data: For Academic/Behavioral referrals only:

a. Attendance: Attach TERMS Attendance page (S242)

b. Social/Medical History: Pertinent Findings ______________________________________

____

c. Previous Psychological: Attached: Date _______ Completed by ____________________

d. Academic Achievement and/or Behavior Tier Interventions completed and attached: ☐ (minimum of two)

III. Information:

What grades has child repeated? ______________________________________
What are the strengths of the student? ______________________________________
Has the student had a prior referral to special education? ______________________________________
Other educational services? Specify: ______________________________________

IV. Office Tracking Log:

______________________________ ______________________________
* Signature of SST Coordinator Date * Signature of Evaluation Specialist Date

	Person	Action	Date	Initials
1	**SST Coordinator**	Must request a referral review prior to obtaining the parent permission to evaluate		
2	**Evaluation Specialist**	Approved referral documents		
3	**SST Coordinator**	Obtain consent to evaluate, keep a copy and give originals to Evaluation Specialist		
4	**Evaluation Specialist**	Requested case number from District Office		

Case Number ______________________ **Expected Due Date** ____________

Monroe County School District
Student Services Team

PARENTAL NOTICE/CONSENT FOR EVALUATION

Student Name: ______________________ School: ______________________

Date: ______________________

Dear ______________________:

In order to develop the best educational programs for your child, we feel that additional information is needed. An individual evaluation is recommended to assist us in meeting the educational needs of your child. The evaluation is proposed based on your child's educational performance and review of any previous evaluation information as well as observations and conference(s). Other factors may have been considered in this proposal. These may have included information from hospitals, doctors, or other social services. The following list of educational options have been considered or used with your child: Title I -Tutoring - Dropout Prevention - Behavior Management - Community Agency Referral - Counseling - Change in level of instruction - Change instructional methods - Other (specify)______________________. The options were determined insufficient in meeting the educational needs of your child and have been rejected as the primary methods of assisting your child.

Do you consent for us to conduct an evaluation or secure information, if necessary, of your child in the areas listed below? May include the following:

( ) Academic Achievement
( ) Vision /Evaluation
( ) Hearing /Evaluation
( ) Medical
( ) Behavioral Observations
( ) Functional Behavior Assessment
( ) Social and Developmental History
( ) Occupational/Physical Therapy Evaluation
( ) Speech and Language /Evaluation
( ) Individual Psychological Evaluation
( ) Individual Intellectual Evaluation
( ) Learning Abilities Evaluation
( ) Assistive Technology /Evaluation
( ) Other:______________________

You will be advised of the results of the evaluation(s). If you have any questions, please feel free to call the SST Coordinator or the Office of Student Services: 305-293-1400 x 53377.

PARENT CONSENT FOR INITIAL PRE-PLACEMENT EVALUATION

☐ YES, I give permission for testing and understand my rights as explained on the Summary of Procedural Safeguards.

☐ NO, I do not give permission for testing for the following reasons:______________________
____

☐ I request a conference before giving permission for testing.

____
Student's Name

Address______________________

____
Date of Birth

____
Parent's Signature

Phone Number______________________

____
Date

As parent(s)/guardian(s) of a child with a suspected disability, you have certain protections under the attached Procedural Safeguards of the Individuals with Disabilities Education Act. For a gifted student, you have protections under the Procedural Safeguards under Rule 6A-6.03313, FAC. Further explanation of rights and copies may be obtained from the ESE Director or the school SST Coordinator at:

______________________ at ______________________
Name Position Phone #

Monroe County School District
Student Services Team
ESE REFERRAL DATA FORM

Student Name: ______________________________

D.O.B.: ______________________________

Grade Level: ______________________________

Upon completion of the referral packet, the following data elements shall be completed by the SST coordinator and provided to the data entry clerk at the school. The clerk enters the data on the **TERMS S704 Panel** and the SST coordinator checks the accuracy.

This is a requirement of the DOE.

ESE Referral Reason: Circle One

D Student suspected of having a disability
G The student is suspected of being gifted
Z Not Applicable (default)

Placement Status

R Referred and pending Evaluation

Date of Referral: ______________

SST Coordinator please note:
Referral date is the date the parent signed permission to complete initial evaluation.

______________________________ ______________
Signature of SST Coordinator Date

______________________________ ______________
Signature of Data Entry Date