CHILD STUDY TEAM MEETINGS

Date	Student	ID#	Teacher/Room	Eval Plan	Eligibility	Other	Test? Y/N
Grade	Parent PDNA☐	DOB	School				

Referral Source: ☐ **Teacher** ☐ **Parent Letter** ☐ **Other :** _____

I&RST Interventions: ☐ Yes ☐ No **Hearing:** ☐ Pass ☐ Fail **Vision** ☐ Pass ☐ Fail ☐ **Logged**

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