CHILD STUDY TEAM MEETINGS

Date	Student	ID#	Teacher/Room	Initial	Re-Eval	Other	Test? Y/N
Grade	Parent PDNA☐	DOB	School				

Referral Source: ☐ **Teacher** ☐ **Parent Letter** ☐ **Other :** _____ **Retained:** ☐ No ☐Yes _____

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

READING

Grade Level:

Decoding:

Oral Reading Fluency:

Comprehension:

Language:

Handwriting:

Spacing and Alignment:

Capitalization/Punctuation:

Sentence Structure:

MATHEMATICS

Grade Level:

Basic Facts: Add _____ Sub _____ Mult _____

Add:

Subtract W/Regrouping:

Multiply:

Divide:

Telling Time:

Word Problems – One Step:

Multi-Step:

SOCIAL SKILLS

Authoritative Relationships:

Peer Relationships:

OVERALL STRENGTHS/WEAKNESSES

HEALTH