*** CONFIDENTIAL ***

Student Support Services

CHILD STUDY PACKET

Student: ________________________ Teacher: ________________________

Child Study Packet Action Documentation

<table>
<thead>
<tr>
<th>Action</th>
<th>Date</th>
<th>Signature</th>
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<tbody>
<tr>
<td>Teacher submits CSP to principal for initial review.</td>
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<tr>
<td>Principal returns CSP to Teacher with notification that SSS Committee Meeting Has Been Scheduled</td>
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<tr>
<td>Teacher Begins the Child Study Packet</td>
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<tr>
<td>Teacher Begins Intervention</td>
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<tr>
<td>Teacher Reviews Intervention Progress</td>
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<tr>
<td>Teacher Submits Child Study Packet to Principal Prior To Scheduled SSS Committee Meeting</td>
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<tr>
<td>SSS Committee Initial Meeting Date (Team Reviews Child Study Packet)</td>
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<tr>
<td>Teacher Revises Child Study Packet and Resubmits to Principal</td>
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<tr>
<td>SSS Committee Review Meeting Date (Team Reviews Results Of Suggested Interventions)</td>
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<td>SSS Committee Referral to Special Education Department</td>
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Dear Teacher,

Enclosed in this folder are the forms that need to be completed in compliance with both federal and state regulations regarding screening of students prior to any referral for supportive services outside of the regular education curriculum (see the box below).

Although certain sections will be completed by other professionals (i.e., school nurse, interventionists, building administrator, etc.) these forms are primarily to be completed by the general education classroom teacher, since the general education classroom teacher is typically the educator who is most familiar with the child’s abilities and needs. Therefore, it is your responsibility to ensure all forms are complete. If you have any questions about the packet or how to complete it, please contact Suzanne Chomas, Director of Special Education, Ext 1100, schomas@keyknox.com, or Michael McCormick, Principal, Ext 1130, mmccormick@keyknox.com.

THE PENNSYLVANIA CODE – 14.122 regarding Screening:

Each school district shall establish a system of screening to accomplish the following:

(1) Identify and provide initial screening for students prior to referral for a special education evaluation.

The screening process shall include:

(1) For students with academic concerns, an assessment of the student’s functioning in the curriculum including curriculum-based or performance-based assessment.
(2) For students with behavioral concerns, a systematic observation of the student’s behavior in the classroom or area in which the student is displaying difficulty.
(3) An intervention based on the results of the assessments under paragraph (1) or (2).
(4) An assessment of the student’s response to the intervention.
(5) A determination as to whether the student’s assessed difficulties are due to a lack of instruction or limited English proficiency.
(6) A determination as to whether the student’s needs exceed the functional ability of the regular education program to maintain the student at an appropriate instructional level.
(7) Activities designed to gain the participation of parents.

If screening activities have produced little or no improvement within 60 school days after initiation, the student shall be referred for an evaluation under 14.123 (relating to evaluation).

Sincerely,

Suzanne Chomas
Director of Special Education
I. Student Demographic Information

A. General Information:
1. Student Name: ___________________ Phone: ___________________
5. Regular Education Teacher: __________________________
6. Does the child currently have an IEP? _____ Yes, Case Manager ________
    _____ No

B. Home Environment:
1. Student lives with (check all that apply):
   ____ Mother
   ____ Father
   ____ Names of Siblings: ________________________________________
   ____ Guardian
   ____ Grandparent(s)
   ____ Friend
   ____ Foster Family
   ____ Shelter
   ____ Sibling
   ____ Other relative – relationship: ________________________________
   ____ Other
2. Custodial Parent/Guardian Name(s): ____________________________
3. Other important information about the custodial parent(s) and/or home environment: __________________________
   ________________________
   ________________________
   ________________________

C. School History
1. Has this student repeated any grades? _____ Yes _____ No
   If the student has repeated grades, which grades have they repeated? __________________
2. Has this student attended other schools? _____ Yes _____ No
   If the student has attended other schools, please list the schools and grades in which they
   attended schools:
   _______________________________ (school) __________________________ (grades attended)
   _______________________________ (school) __________________________ (grades attended)
   _______________________________ (school) __________________________ (grades attended)
3. Check all past and present services/programs that apply to this student (Note: If you check a box and there is an *italics* section below that item, you must complete the additional information):

___ Early Intervention

___ Title 1 Reading Services  
*Date Services Began:*____________  *Reason for Services:*____________

___ Head Start

___ Pre-K Counts

___ Home Schooling

___ Homebound Instruction

___ School Counseling Services

___ Counseling in the Community  
*Counselor/Agency:*____________  *Date Services Began:*________

___ Occupational Therapy in the School  
*Therapist’s Name:*____________  *Frequency of Service:*________

___ Occupational Therapy in the Community  
*Service Provider:*____________  *Date Services Began:*________

___ Physical Therapy in the School  
*Therapist’s Name:*____________  *Frequency of Service:*________

___ Physical Therapy in the Community  
*Service Provider:*____________  *Date Services Began:*________

___ Speech/Language Therapy in the School  
*Therapist’s Name:*____________  *Frequency of Service:*________

___ Speech/Language Therapy in the Community  
*Service Provider:*____________  *Date Services Began:*________

___ Chapter 15 (“504 Service Agreement”)  

___ Chapter 16 (“Gifted Services”)  

___ Other Community Agency:___________________________________________

___ Other, *Please Explain:*___________________________________________
D. Reason for Referral
Please summarize why you are referring this student.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

E. Strengths, Concerns, and Recommendations:
Please list student strengths:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please list your concerns for this student:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What do you recommend would help to support this student’s learning?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
II. Student’s Assessment Records

A. Dynamic Indicators of Basic Early Literacy Skills (DIBELS):
   ___CHECK here if the student has not been administered this assessment.

<table>
<thead>
<tr>
<th>Skill</th>
<th>Beginning of Year</th>
<th>Middle of Year</th>
<th>End of Year</th>
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<tbody>
<tr>
<td>First Sound Fluency (FSF)</td>
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<td>Letter Naming Fluency (LNF)</td>
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<td>Phoneme Segmentation Fluency (PSF)</td>
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<td>Nonsense Word Fluency (CLS)</td>
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<td>Nonsense Word Fluency (WWR)</td>
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<td>DIBELS Oral Reading Fluency (DORF Fluency)</td>
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<td>DIBELS Oral Reading Fluency (DORF Accuracy)</td>
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<td>DIBELS Oral Reading Fluency (DORF Retell)</td>
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<td>DIBELS Maze (Daze)</td>
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<td>DIBELS Progress Monitoring</td>
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</tbody>
</table>

B. STAR
   ___CHECK here if the student has not been administered this assessment.

<table>
<thead>
<tr>
<th>Skill</th>
<th>Beginning of Year</th>
<th>Middle of Year</th>
<th>End of Year</th>
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<tbody>
<tr>
<td>Reading</td>
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<tr>
<td>Math</td>
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</tbody>
</table>

C. Pennsylvania System of School Assessment (PSSA):
   ___CHECK here if the student has not been administered this assessment.

   Grade Student was administered PSSA: ____________

   Please complete the table below:

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Level (i.e., Proficient, Below Basic, Advanced, etc.)</th>
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</thead>
<tbody>
<tr>
<td>ELA</td>
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<tr>
<td>Math</td>
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<td>Science</td>
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</table>

D. Other Assessment(s), such as Title 1:
   ___CHECK here if the student has not been administered this assessment.

   Grade Student was administered the assessment: ____________

   Please complete the table below:
III. School Health Information

Note: This page should be completed by the school nurse and returned to the BUILDING PRINCIPAL for inclusion in the Child Study Packet.

STUDENT NAME: ___________________________   BD: ____________

A. Health History:
1. Does this child have allergies?  _____ Yes  _____ No
   If yes, please indicate what type of allergies: ________________________________

2. Does this child have any diagnoses/disorders/chronic health problems (i.e., inner ear infections, asthma, cancer, ADHD, etc.)?  _____ Yes  _____ No
   If yes, please provide more specific information: ________________________________
   ________________________________
   ________________________________

3. Does this child take medications?  _____ Yes  _____ No
   If yes, please indicate what type of medication, dosage, and why the student takes the medication:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Reason</th>
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</table>

4. Is there a record of pregnancy, birth, or developmental difficulties/delays?  _____ Yes  _____ No
   If yes, please provide more specific information: ________________________________
   ________________________________
   ________________________________

5. Has this student been hospitalized for any reason?  _____ Yes  _____ No
   If yes, please provide more specific information: ________________________________
   ________________________________
   ________________________________

B. Current Health Information:
1. Vision
   Date of Most Recent Screening: ____________  Result: ________________________________
   Were lenses worn as prescribed?  _____ Yes  _____ No
   Were corrective lenses prescribed?  _____ Yes  _____ No
2. Hearing
   Date of Most Recent Screening: ___________ Result: ________________________
   Were hearing aids worn as prescribed? _____Yes _____No
   Were hearing aids prescribed? _____Yes _____No

3. How many times has this student been to the nurse’s office during the *previous* school year and what was the primary reason for the visits?

<table>
<thead>
<tr>
<th>Number of Visits</th>
<th>Primary Reason for Visits</th>
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</table>

4. How many times has this student been to the nurse’s office during the *current* school year and what was the primary reason for the visits?

<table>
<thead>
<tr>
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C. Additional Health Information:
   Please list any additional concerns and/or comments: ________________________________
   __________________________________
   __________________________________
   __________________________________
   __________________________________
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   __________________________________
   __________________________________
IV. Student Assistance Program (SAP)

Note: This page should be completed by the SAP Coordinator in the student’s school of attendance. It should be returned to the BUILDING PRINCIPAL for inclusion in the Child Study Packet.

STUDENT NAME: ___________________________ BD: __________

Please provide any additional information about this child: ___________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

SAP Referral Recommended by: ___________________________
**Custodial Parent/Guardian Communication**

**A. Prior to Start of Child Study Packet Process:**

1) Person contacting custodial parent/guardian:__________________________
   Date of Contact: ______________
   Name of Parent/Guardian contacted:______________________________
   Summary of conversation (include parent’s response):__________________________
   ________________________________________________________________________
   ________________________________________________________________________

2) Person contacting custodial parent/guardian:__________________________
   Date of Contact: ______________
   Name of Parent/Guardian contacted:______________________________
   Summary of conversation (include parent’s response):__________________________
   ________________________________________________________________________
   ________________________________________________________________________

**B. During Child Study Packet Process:**

1) Person contacting custodial parent/guardian:__________________________
   Date of Contact: ______________
   Name of Parent/Guardian contacted:______________________________
   Summary of conversation (include parent’s response):__________________________
   ________________________________________________________________________
   ________________________________________________________________________

2) Person contacting custodial parent/guardian:__________________________
   Date of Contact: ______________
   Name of Parent/Guardian contacted:______________________________
   Summary of conversation (include parent’s response):__________________________
   ________________________________________________________________________
   ________________________________________________________________________

3) Person contacting custodial parent/guardian:__________________________
   Date of Contact: ______________
   Name of Parent/Guardian contacted:______________________________
   Summary of conversation (include parent’s response):__________________________
   ________________________________________________________________________
   ________________________________________________________________________
VI. Strategies and Accommodations

A. **Academic Strategies/Accommodations:**
Please complete the tables below.

**NOTE:** Examples of strategies/accommodations are: repeating directions, chunking work into smaller amounts, highlighting math symbols, allow for longer response/completion time, providing a calculator, using a timer, proximity seating, etc.

<table>
<thead>
<tr>
<th>Effective Academic Strategies/Accommodations</th>
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<tbody>
<tr>
<td>Date Began</td>
<td>Strategy / Accommodations</td>
<td>Evidence of the Effectiveness of the Strategy / Accommodations</td>
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<tr>
<th>Ineffective Academic Strategies/Accommodations</th>
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<td>Date Began</td>
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<td>Evidence of the Effectiveness of the Strategy / Accommodations</td>
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</table>

B. **Behavioral Strategies/Accommodations:**
Please complete the tables below.

**NOTE:** Examples of strategies/accommodations are: repeating directions, chunking work into smaller amounts, highlighting math symbols, allow for longer response/completion time, providing a calculator, using a timer, proximity seating, etc.

<table>
<thead>
<tr>
<th>Effective Behavioral Strategies/Accommodations</th>
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<tbody>
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<td>Date Began</td>
<td>Strategy / Accommodations</td>
<td>Evidence of the Effectiveness of the Strategy / Accommodations</td>
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VII. Documentation of Intervention(s)
(To be determined at the Child Study Team meeting)

A. Targeted Skill:
Please review your list of concerns in Section VI.A.2 on page 10 of this “Child Study Packet.” Below, identify your primary concern, or the concern you have chosen to target for intervention.

NOTE: Examples of target skills include: reading fluency, time on-task, reading comprehension, compliance, addition/subtraction problems, etc.

My target skill is: __________________________________________

B. Intervention:
Please select an evidence-based intervention.

NOTE: If you need assistance in selecting an evidence-based intervention, please work with your guidance counselor, principal, or director of special education.

I have selected the following evidence-based intervention: ________________________

C. Intervention:
Please indicate what data you will use to determine the effectiveness of the evidence-based intervention you are implementing.

NOTE: Examples of data-collection methods include: performance on DIBELS/CIRCLES, frequency count (i.e., tallies), score on a rubric, performance on classroom assessment, math addition/subtraction sheet, tracking duration, etc. If you need assistance in determining a data collection method, work with your counselor, principal, or director of special education.

I will be using the following data to determine the effectiveness of the evidence-based intervention: ________________________

D. Baseline Data:
“Baseline” information is essential to determining the effectiveness of an intervention. Baseline data is the data collected prior to implementing an evidence-based intervention. Therefore, it is essential to record data PRIOR to the implementation of the intervention. Using the data collection method you selected above in section VIII.C.1., please record the student’s performance/score/frequency/etc. below.

NOTE: You must have at least 3 data points; however, 6 to 8 data points is ideal.

<table>
<thead>
<tr>
<th>Date of Baseline Data Collection</th>
<th>Data Collection Method</th>
<th>Student’s Baseline Performance/Score/Frequency/etc.</th>
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E. Goal:
1. A goal is developed by comparing the student’s baseline performance to local, state, or federal norms; benchmarks; reasonable rate of improvement; etc.
   My goal for this student’s performance is: ________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
F. Results

1. Using the data collection method you selected above in section VIII.C.1., please record the student’s performance/score/frequency/etc. below. The data you record below should ONLY include data from the time the evidence-based intervention was implemented.

Note: You should have a minimum of 6 to 8 data points (occurring 1 time per week for 6 to 8 weeks). However, 12 to 16 data points (occurring 2 times per week for 6 to 8 weeks) is ideal.

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<tr>
<th>Date of Data Collection</th>
<th>Data Collection Method</th>
<th>Student’s Performance/Score/Frequency/etc.</th>
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Comments/Additional Thoughts (if applicable)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Intervention Reflection

A. Integrity

1. Did you implement the intervention the “way it was intended to be implemented?”
   _____ Yes  _____ No

2. Did you implement the intervention for an appropriate length of time (i.e., 6 to 8 weeks)?
   _____ Yes  _____ No

B. Data Analysis

1. Are you able to objectively analyze the data?”
   _____ Yes  _____ No

2. In your opinion, does the data suggest that the student continues to struggle and has shown no improvement?
   _____ Yes, the student continues to struggle and has shown no improvement.
   _____ No, the student is no longer struggling and has shown improvement.
   _____ No, the student continues to struggle. However, the student has shown improvement.

PLEASE ATTACH ASSESSMENT RESULTS
### Student Support Services Committee Minutes

**Child Study Plan**

**Student:** ____________________________  **DOB:** __________  **Grade:** _____  **HomeRoom:** ____________

**School:** ____________________________  **SSS Meeting:** ____________  **SSS Follow-up:** ____________

<table>
<thead>
<tr>
<th>Action to be taken</th>
<th>Responsible party</th>
<th>Date completed</th>
<th>Notes</th>
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**Committee Members:**

- **Principal/Designee** ____________________________
- **Referring Source/Title** ____________________________
- **Teacher (If not referring source)** ____________________________
- **Specialist** ____________________________
- **Other** ____________________________
- **Other** ____________________________