Guam Department of Education
Child Study Team Referral
FORM ONE – A

CST REFERRAL: A Child Study Team (CST) referral is initiated when a student has been identified as needing additional supports based on academic, behavioral, social-emotional and other challenges. This CST Referral (Form A) and Parent/Guardian Information (Form B) can be completed by a teacher, parent/guardian, student, other school personnel, representatives of community agencies, or other individuals.

CST TIMELINES: Upon submission of this referral form to the School Administrator, a CST meeting shall take place no more than 30 working days from the date the referral submitted. <u>If the referral is made within 30 working days before the last day of school, the CST Coordinator must ensure that a CST staffing takes place within 10 days after the beginning of the following school year.</u>

Student Name: ______________________________ **Student #:** _____________________ **DOB:** _______________

Grade: _______ **School:** _____________________________ **Referral Submission Date:** ______________________

Check all that apply:

❑ Academic PowerSchool grades attached: ☐ YES ☐ NO

❑ Behavior ODRs attached: ☐ YES ☐ NO

PowerSchool Log Entries attached: ☐ YES ☐ NO

OTRFs attached: ☐ YES ☐ NO **SARF attached:** ☐ YES ☐ NO

PowerSchool Attendance attached: ☐ YES ☐ NO

❑ Health Supporting documents attached: ☐ YES ☐ NO

❑ Social/Emotional Supporting documents attached: ☐ YES ☐ NO

❑ Communication Supporting documents attached: ☐ YES ☐ NO

❑ Fine/Gross Motor Skills Supporting documents attached: ☐ YES ☐ NO

❑ Other: ____

Write a brief statement about the concern(s):

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____

____

____

Guam Department of Education
Child Study Team Referral
PARENT/GUARDIAN INFORMATION
FORM ONE – B

Mother/Guardian Name: ____ Contact #:___________________________

Email: ____ Other Contact #: __________________________________

Father/Guardian's Name: ____Contact #:_________________________

Email: ____ Other Contact #: __________________________________

Home Address: ____

Mailing Address: ____

Is the parent/guardian aware of your concern? ❑ YES ❑ NO

If "No", explain ____

Does the student need an interpreter? ❑ YES ❑ NO Does the parent need an interpreter? ❑ YES ❑ NO

Referring Individual Name and Relationship to Student: ____

Referring Individual Signature and Date: ____

FOR SCHOOL USE ONLY:

Date Received by School Staff:	School Staff Name & Signature:
Date School Administrator Received Referral:	School Administrator Name & Signature:
Name of CST Coordinator Assigned:	Date Received by CST Coordinator:

PARENT CONTACT LOG		
Date & Time:	**Form of Contact** (i.e. Phone, Email, Face-to-Face Meeting)	**Notes** (Person contacted, information discussed)

RESPONSE FOR ASSISTANCE: FORM TWO - A BEHAVIOR INFORMATION	Student: ___________________________________ Student #:__________________________________

Information may be obtained by the school administrator or by reviewing the student's PowerSchool and/or PULSE, and CUMULATIVE file. This form is to be completed using the most current and relevant information.

School Administrator's Name: ____

A. Is communication with parent regular and consistent? ☐ YES ☐ NO

B. Student Conduct:

# of Office Discipline Referrals:		# of Suspensions:	# of Suspensions:
# of Absences:	# of Unexcused Absences:	# of Excused Absences:	# of Tardies:
# of Office Truancy Referrals:		# of SARFs:	

Log Entries Attached: ☐ YES ☐ NO

C. Function of Behavior Assessment: ☐ YES ☐ NO

Date of the FBA: __________________ FBA Attached: ☐ YES ☐ NO

Behavior Intervention Plan or Behavioral Management Plan: ☐ YES ☐ No

Date of the BIP/BMP: _______________ BIP or BMP Attached: ☐ YES ☐ NO

D. Other Screeners/Assessments ☐ YES ☐ NO

If yes, specify Screeners/Assessments: ___________________________ Date Completed: _________

Results of screener/assessment indicated above:

____
____
____
____
____
____

E. Other Information

Provide details on other interventions that have been provided by school administration that may help in identifying what supports the student can benefit from:

____
____
____
____
____
____

RESPONSE FOR ASSISTANCE: FORM TWO – B SPECIAL PROGRAM INFORMATION	Student: ___________________________________ Student #:_________________________________

Information may be obtained from your ESL Coordinator, school counselor or from reviewing the student's PowerSchool/PULSE and CUMULATIVE file. This form is to be completed using the most current and relevant information.

ESL Coordinator or School Counselor's Name: ____

ESL: ☐ YES ☐ NO

Date of Entry to ESL Program: _____________ Date of Student ESL Modification Form: _______________

HLS attached: ☐ YES ☐ NO If no, why? ____

Primary Language: _______________________

LAS (*if applicable*) **are attached:** ☐ YES ☐ NO

List of ESL services provided:

____

Comments for ESL:

____

School Counselor

Has this student ever been retained? ☐ YES ☐ NO If "Yes", when? __________________________

Refer to GEBP 339: Promotion and Retention Early Granting of Credits.

Is there anything you know about the student's background, home situation or other factors that may contribute to the student's difficulties?

____

____

Supportive Counseling: ☐ YES ☐ NO

Comments for Supportive Counseling:

____

____

Other Screeners/Assessments: ☐ YES ☐ NO

If yes, specify Screeners/Assessments used:

____Date completed: ___________________

Results of screener/ assessment indicated above:

____

RESPONSE FOR ASSISTANCE: FORM TWO – C STUDENT HEALTH INFORMATION	Student: ___________________________________ Student #:__________________________________

School Health Counselor is to complete this form using the most current and relevant information.

School Health Counselor's Name: ____

Date of the Last Physical (within 12 months to be valid): ______________________________

❑ Vision Screening Date (within 12 months to be valid): _____________________________

☐ Passed ☐ Failed

❑ Follow-up needed: _________________

Wears glasses? ☐ YES ☐ NO

Right: _____________________

Left: _____________________

❑ Hearing Screening Date(within 12 months to be valid): ________________________

Tympanogram: ☐ Passed ☐ Failed

Pure Tone: ☐ Passed ☐ Failed

Follow-up needed/comments: ___________________________

Individualized Health Plan in place: ☐ YES ☐ NO

Other Screeners/Assessments ☐ YES ☐ NO

If yes, specify Screeners/Assessments used: ____

Date completed: ________________________

Results of screener/assessment indicated above: _______________________________________
____
____

Other medical information that may impact the student's ability to succeed (diagnosis/medication/allergies/etc.):

____
____

RESPONSE FOR ASSISTANCE: FORM TWO –D– 1 **PRESENT LEVEL OF ACADEMIC & FUNCTIONAL PERFORMANCE/ TEACHER WRITTEN INPUT**	**Student:** ___________________________ **Student #:** _________________________

Teacher is to complete this form using most current and relevant information.

Teacher's Name: ____

Class/Subject: ____

Student Work Samples Attached: □ **YES** □ **NO**

ACADEMICS
Current grade (percentage): _______________ Is student achieving at grade-level? ___________________ Date of assessment: __________ Type of assessment:_________________ Grade Level Equivalency: _________ Pre-Test Score: __________ Date: __________ Post-Test Score: __________ Date: ____________   **Reading:** (fluency, reading rate, comprehension, etc.) How many words can he/she read in a minute?_________ Number of errors?_______ Fluent? ________________ Can he/she answer who, what, when, where, why and how questions in oral & written format?   **Language Arts:** (writing, spelling, etc.) Can he/she write complete sentences? How's noun/verb agreement? Correct punctuation and capitalization? Can he/she write paragraphs? What type of words is he/she able to spell? Consonant-Vowel-Consonant, etc.?   **Math:** (problem solving, computations, etc.) Can he/she: identify numbers?_______Solve word problems? Can he/she add, subtract, multiply or divide?_____What kind of numbers? (Example: 2x2 digit with regrouping/renaming?)   **Other subjects (Example: SC, SS, PE, CHAM, etc.):**

RESPONSE FOR ASSISTANCE: FORM TWO –D– 2 PRESENT LEVEL OF ACADEMIC & FUNCTIONAL PERFORMANCE/ TEACHER WRITTEN INPUT	Student: ____________________________ Student #: __________________________

Social / Emotional Behavior:
Does he/she follow classroom/school rules? Does he/she get along with peers? How well does he/she adjust to changes? How well does he/she deal with stressful situations? Can he/she sit and attend to a task for the entire duration of task given? *Strengths:* *Areas for growth:*
Communication:
Can the student speak in complete sentences? How's noun/verb agreement? Can he/she express wants and needs in complete sentences?
Fine Motor Skills:
Can he/she manipulate writing objects with correct grasp?___ If not, how? Left/right handed? Does he/she put enough pressure when utilizing writing objects? Able to cut on line with scissors? What kind of lines? *****Bring work samples*******
Gross Motor Skills:
Can he/she walk, run, jump, skip, climb, go up and down the stairs? Does he/she need to hold onto rail? Is he/she able to throw and catch a ball? Does he/she show motor control?
Self-care / Independent Living Skills:
Can child feed herself/himself? Dress/undress independently? Tie shoes? *Strengths:* *Areas for growth:* *List all interventions, modifications , and/or accommodations you use for the student to achieve success in the classroom:*

RESPONSE FOR ASSISTANCE: FORM TWO- E **OTHER PERSONNEL INFORMATION**	**Student:** ______________________________ **Student #:** ______________________________

The School Attendance Officer is to complete this form using the most current and relevant information.

School Attendance Officer's Name: ____

OTRFs attached: ☐ Yes ☐ No
Comments:

____

____

SARF attached: ☐ Yes ☐ No
Comments:

____

____

Response to OTRF/SAR attached: ☐ Yes ☐ No

____

____

Truancy Checklist Results attached: ☐ Yes ☐ No

If yes, specify Screeners/Assessments used: ____________________________ Date completed: ___________

Results of screener/assessment indicated above:

____

____

The Social Worker is to complete this form using the most current and relevant information.

Social Worker's Name: ____

SPCE Support Services & Outreach Team Referral attached:
Comments: ____

SPCE Support Services & Outreach Team Response to Referral attached: ☐ Yes ☐ No
Comments:

____

____

Non-Instructional Personnel is to complete this form using the most current and relevant information.

Non-Instructional Personnel's Name: ____

Supporting Documents attached: ☐ YES ☐ NO Comments:

____

____

CST COMMITTEE NOTICE: FORM THREE	Student: ___________________________ Student #:__________________________

Date: ____________________

Identified Committee Members:

- ❑ Student
- ❑ Parents/Guardians (required)
- ❑ CST Facilitator – School Administrator (required)
- ❑ CST Coordinator – Certified personnel (required)
- ❑ General Education teacher(s) [must be the student's teacher(s)] (required)
- ❑ School Health Counselor
- ❑ School Counselor
- ❑ CRT/IEPC
- ❑ Referring individual
- ❑ Special Education/ESL teacher
- ❑ ESL Coordinator
- ❑ School Attendance Officer
- ❑ Social Worker
- ❑ Others (i.e. instructional coach, department chairpersons, itinerant teacher, one-to-one aide, etc.)

There will be a ☐ ***CST Staffing for:*** ☐ ***CST Meeting for:***

Student Name: ____ **DOB:** __________________________

Grade Level: ____________ **on (date)** _______________**at (time)** ____________ **in (room)** _____________.

A referral was submitted on _____________________________________ in the area of:

❑ Academic	❑ Behavior	❑ Health	❑ Social/Emotional
❑ Communication	❑ Fine/Gross Motor Skills		❑ Other:________________

If there is an attachment for you to complete, please submit to __________________________ before the scheduled meeting.
CST Coordinator

Thank you.

____

School Administrator's Name and Signature

PLAN OF ACTION: FORM FOUR – A-1 ☐ CST STAFFING ☐ CST MEETING (check one)	Student: ____________________________ Student #:___________________________

Date: _______________________ Time: _______________ Location: ___________________

Committee Members Present (Print Name and Initial):

- ❑ Student ____
- ❑ Parents/Guardians (required) ____
- ❑ CST Facilitator – School Administrator (required)____
- ❑ CST Coordinator – Certified personnel (required)____
- ❑ General Education teacher(s) (must be the teacher(s) of the student) (required)
  ___________________ ___________________ ____________________ _____________________
  ___________________ ___________________ ____________________ _____________________
- ❑ School Health Counselor____
- ❑ School Counselor____
- ❑ CRT/IEPC____
- ❑ Referring individual____
- ❑ Special Education/ESL teacher____
- ❑ ESL Coordinator____
- ❑ School Attendance Officer____
- ❑ Social Worker____
- ❑ Others (i.e. instructional coach, department chairpersons, itinerant teacher, one-to-one aide, etc.)
  __________________ __________________ ____________________ _______________

Agenda Part I

- ❑ Introductions
- ❑ Referring Individual
- ❑ Brief Statement about the Concern

NOTES:

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- ❑ Presentation of Responses for Assistance Forms

Agenda Part II

- ❑ Documentation of Intervention Strategies Implemented

After reviewing the student's existing data, work samples, and all information provided by parents/guardians, and the CST members, the committee makes the following **SUMMARY** regarding the targeted area(s) of concern and frequency/severity/duration. Additionally, the CST members have included information regarding the outcomes from the interventions attempted.

CST SUMMARY

1. AREA OF CONCERN:		
INTERVENTIONS IMPLEMENTED	**FREQUENCY/SEVERITY/DURATION INTERVENTION DATES**	**OUTCOMES**

2. AREA OF CONCERN:		
INTERVENTIONS IMPLEMENTED	**FREQUENCY/SEVERITY/DURATION INTERVENTION DATES**	**OUTCOMES**

3. AREA OF CONCERN:		
INTERVENTIONS IMPLEMENTED	**FREQUENCY/SEVERITY/DURATION INTERVENTION DATES**	**OUTCOMES**

☐Further Interventions/Accommodations

- ❑ Remedial Reading/Math
- ❑ Modified Curriculum
- ❑ Adapted Materials
- ❑ Tutoring
- ❑ Extended Time
- ❑ Other:________________
- ❑ Talking with parents/guardians
- ❑ Behavior Contract
- ❑ Monitoring Charts
- ❑ Timeout
- ❑ Repeated Directions
- ❑ Other:_______________
- ❑ Detention
- ❑ Lost of Privileges
- ❑ Cooperative Learning
- ❑ Eliminate Distracters
- ❑ Preferential Sitting
- ❑ Other:_____________

PLAN OF ACTION: FORM FOUR-A-2	**Student:** ______________________________________ **Student #:** _____________________________________

PLAN OF ACTION: SCHOOL-LEVEL INTERVENTION(S)

NOTE: Do not delay the implementation of this plan due to the parent's inability to meet.

Interventions **Recommended at the 1st CST meeting**	**Dates of Implementation** (Approx. 4-6 weeks in duration; indicate start and end dates)	**Outcomes** **To be discussed at the 2nd CST meeting**

Other recommendations (i.e. update physical exam, other evaluations, attendance referral, etc.)

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CHILD IDENTIFICATION CHECKLIST -FORM FIVE **(Completed by the teacher prior to the CST meeting)**	**Student: ___________________________** **Student #:___________________________**

Academics	Yes	No
Comprehends grade level texts and materials	❒	❒
Writes/prints legibly	❒	❒
Spelling is average	❒	❒
Copies information from the board easily	❒	❒
Identifies numbers	❒	❒
Writes numbers	❒	❒
Adds:	❒	❒
Subtracts:	❒	❒
Multiplies:	❒	❒
Divides:	❒	❒
Solves word problems	❒	❒
Tells time	❒	❒
Identifies coins and bills	❒	❒
Completes assignments on time.	❒	❒
Organizes school materials & assignments	❒	❒
Follows oral / written directions	❒	❒

Communication	Yes	No
Receiving ESL services	❑	❑
Has been seen or referred for ear, nose or throat problem?	❑	❑
Has known medical/emotional problems that may have an effect on speech?	❑	❑
Has been referred for or received speech and language services in the past?	❑	❑
Uses gestures to communicate	❑	❑

Articulation	Yes	No
Able to produce all age appropriate speech sounds clearly	❑	❑
Student's conversational speech is easily understood by the average listener	❑	❑
Student's speech is free of immature or "babyish" sounds	❑	❑

Behavior	Yes	No
Brings appropriate materials to school	❒	❒
Asks questions	❒	❒
Changes activities without incident	❒	❒
Listens	❒	❒
Uses socially acceptable language	❒	❒
Demonstrates appropriate way for getting attention	❒	❒
Shares	❒	❒
Tells the truth	❒	❒
Gets along with peers	❒	❒
Participates in classroom activities	❒	❒
Follows rules of situation, activity or environment	❒	❒
Accepts responsibility for own behavior	❒	❒
Stays on tasks to completion	❒	❒
Works cooperatively	❒	❒
Controls anger	❒	❒
Gets along with adults (teachers, aides, etc.)	❒	❒
Consistently attentive	❒	❒

Language-Auditory Reception/Comprehension	*Yes*	*No*
Able to follow directions with no difficulty	❒	❒
Able to respond accurately to questions	❒	❒
Able to retain information given verbally	❒	❒

Sign Language	*Yes*	*No*
Uses formal sign language	❒	❒
Uses idiosyncratic or personalized signs	❒	❒

CHILD IDENTIFICATION CHECKLIST (continued)	Student: ___________________________ Student #:__________________________

Pragmatics	*Yes*	*No*
Stays on topic being discussed	❐	❐
Able to understand cause & effect	❐	❐
Makes eye contact when talking	❐	❐
Likes talking with people	❐	❐
Takes turns in conversations	❐	❐

Fluency/Stuttering	*Yes*	*No*
Speech rate is appropriate	❐	❐
Able to respond to discussion questions, and produce spontaneous expression without hesitations or repetitions.	❐	❐
Student is free of secondary signs of physical struggle when speaking (facial grimaces, eye or head jerks, rapid eye movements)	❐	❐

Motor Skills	*Yes*	*No*
Referred for physical therapy services in the past *(Give date if yes):*	❐	❐
Had orthopedic or neurological surgery. (If yes, describe in "any other" box below.)	❐	❐
Walks independently, without support.	❐	❐
Check any of the following used by the student:	❐	❐
❑ *Wheelchair* ❑ *Cane* ❑ *Walker*	❐	❐
❑ *Crutches* ❑ *Braces* ❑	❐	❐
Goes up and down stairs without help	❐	❐
Walks and runs with coordinated movements.	❐	❐

Dressing, Hygiene, Toileting	*Yes*	*No*
Dresses and undresses like others of similar age	❐	❐
Washes/dries hands like others of similar age	❐	❐
Uses toilet independently.	❐	❐

Voice	*Yes*	*No*
Has a physician referred this child for voice therapy?	❐	❐
Voice is free of hoarse, harsh or nasal qualities	❐	❐
Student is free of intermittent voice loss during speaking or reading	❐	❐

Visual Perception	*Yes*	*No*
Eyes work together normally	❐	❐
Copies from the board with ease.	❐	❐
Copies from book or paper with ease.	❐	❐
Uses letters or numbers age appropriately	❐	❐
Uses good posture for writing and reading	❐	❐

Socialization	*Yes*	*No*
Interacts appropriately with peers	❐	❐
Shares with peers appropriately	❐	❐
Control of anger and frustration is age appropriate	❐	❐
Initiates play with peers.	❐	❐
Responds appropriately to natural cues in the environment (peers, bell, clock, adult).	❐	❐
Works well in large group settings.	❐	❐
Able to take turns in group settings	❐	❐

Cognition	*Yes*	*No*
Has appropriate attention and/or concentration	❐	❐
Uses problem solving skills appropriately	❐	❐
Able to remember information	❐	❐

CHILD IDENTIFICATION CHECKLIST (continued)	Student: ___________________________ Student #:__________________________

Tactile	*Yes*	*No*
Responds appropriately to touching objects or contact with people/environment	❐	❐
Can restrain from touching items that are "off limits"	❐	❐
Tolerates messy activities	❐	❐

If the Child Study Team's final decision to refer to Special Education, please indicate the areas of assessments for this child.

- ❑ Psychological Services
- ❑ Speech & Language
- ❑ DHHP
- ❑ Vision
- ❑ OT
- ❑ PT
- ❑ Leisure Education
- ❑ Emotional Disabilities
- ❑ Assistive Technology
- ❑ Autism
- ❑ Behavioral

CST REFERRAL DECISION-FORM SIX	**Student: ______________________________** **Student #:_____________________________**

Dear Parent/Guardian,
Your child was referred to the Child Study Team (CST) at school due to issues regarding _________________________. Based on all the documentation, data, information, and other pertinent material, the CST is recommending the following:

- ❑ Child should be referred for possible evaluation by Special Education.
  ***Submit a completed copy of the CST Packet to the respective IEPC/CRT.**
  DATE SUBMITTED:___________________
- ❑ Child should be referred for possible referral for Section 504.
  ***Submit a completed copy of the CST Packet to the respective school counselor.**
  DATE SUBMITTED:____________________
- ❑ Child should be referred for evaluation by District Psychologist.
  ***Submit a completed copy of the CST Packet to the respective school counselor along with Permission to Evaluate see SOP 1200-019.**
  DATE SUBMITTED:____________________
- ❑ Child will be referred to Child and Adolescent Services Division (I Famagu'on-ta)
  ***Submit a completed copy of the CST Packet to the respective school counselor to initiate the Inadahi process. The appropriate Consent to Release Information MUST be signed by parent/guardian.**
  DATE SUBMITTED:____________________
- ❑ Child should be referred to an outside agency.
  ***Submit a completed copy of the CST Packet to the respective school-level designee, parent/guardian and appropriate agency. The appropriate Consent to Release Information MUST be signed by parent/guardian.**
  DATE SUBMITTED:________________________
- ❑ Documentation does NOT support the need for a referral at this time. <u>The CST will develop alternative school-level intervention plans.</u>
  ***Provide a completed copy of the CST Packet to the parent/guardian.**
  DATE PROVIDED TO PARENT/GUARDIAN:_______________________
- ❑ If parent is not present at this meeting, referring teacher, or other appropriate school designee, will discuss this decision with parents and will explain options available to the parents/guardians.
  ***Provide a completed copy of the CST Packet to the parent/guardian.**
  DATE INFORMATION WAS PROVIDED TO PARENT/GUARDIAN: ________________________
- ❑ Child will be retained in/promoted to the ___________ grade level.
  ***Refer to BP339:** Promotion and Retention Early Granting of Credits

NOTE: All the original copies of the CST packet MUST be filed in the student's cumulative folder.

❒ Parent/Guardian refuses the CST Referral Decision as indicated above.
Reasons: ____

____

___________________________________ ___________________________________ _________________
Parent/Guardian Print Name | Parent/Guardian Signature | Date

CST REFERRAL DECISION (continued)	Student: ______________________ Student #:_____________________

DATE: __________________

CST MEMBER SIGNATURES:	PRINT NAME	SIGNATURE
Student	____________________	____________________
Parents/Guardians	____________________	____________________
CST Facilitator – School Administrator	____________________	____________________
CST Coordinator – Certified personnel	____________________	____________________
General Education teacher(s)		
(must be the teacher(s) of the student)	____________________	____________________
	____________________	____________________
	____________________	____________________
	____________________	____________________
School Health Counselor	____________________	____________________
School Counselor	____________________	____________________
CRT/IEPC	____________________	____________________
Referring individual	____________________	____________________
Special Education/ESL teacher	____________________	____________________
ESL Coordinator	____________________	____________________
School Attendance Officer	____________________	____________________
Social Worker	____________________	____________________

Others (i.e. instructional coach, department chairpersons, itinerant teacher etc.)

________________ ________________ ________________ ________________

DEPARTMENT OF EDUCATION
OFFICE OF THE SUPERINTENDENT

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JON J.P. FERNANDEZ
Superintendent of Education

PARENT/GUARDIAN NOTIFICATION FOR CHILD STUDY TEAM MEETING-FORM SEVEN

This is to inform you that a referral to conduct a Child Study Team (CST) has been made for your child. A CST referral is initiated when a student has been identified as needing additional supports based on academic, behavioral, social-emotional, and/or other challenges. The CST is designed to provide classroom teachers with instructional supports and strategies for helping students in need of assistance. The team of school-level professionals provide ideas to classroom teachers on methods for helping students experiencing academic or behavioral problems. To achieve this, schools collaborate with appropriate team members as well as research strategies that result in targeted, school-level interventions.

Your attendance, participation and input is greatly needed to ensure that your child is provided with appropriate interventions or referral (SPED, Section 504, outside agency) to support his/her success.

Student: ______________________________ DOB: ______________ Grade: _____School: ________________

CST Meeting Details: Date_______________Time_______________Location___________________________

Your child was referred based on information/data concerning:

- ☐ Academic
- ☐ Health
- ☐ Other: ______________________________
- ☐ Behavior
- ☐ Social/Emotional

Your signature indicates that you are aware of the CST meeting and that you agree to attend, participate, and provide valuable input as a member of your child's Child Study Team. Please sign and return to ________________________________. Is an interpreter needed for you? ☐ Yes ☐ No

______________________________________ ____

School Administrator's Name and Signature **Parent/Guardian's Name and Signature**

If you are unable to attend, please indicate other dates and times when you are available below. A school official will contact you to confirm a date and time.

Parent/Guardian's Name and Signature: __________________________ **Date**: _______________________