JAMP Special Education Services

Referral for Multi-Disciplinary Evaluation

Student's Full Name:	SSID:	
Date of Birth:	Gender:	Race/Ethnicity:
Student Represented by: ☐ Parent ☐ Guardian ☐ Self ☐ Surrogate		
Does Student Live with Parents? ☐ YES ☐ No		
If No, With Whom Does the Student Live?:	Relationship:	
Parent/Guardian:		
Home Address:		
Home Phone:	Work Phone:	
Primary Mode of Communication of the Student:		
Primary Mode of Communication in the Home:		
General Education Teacher:	Grade:	
Referring Person/Title:		

Major Areas(s) of Concern: Check each reason for referring this student:

☐ Cognitive Functioning

- ☐ Understanding New Concepts
- ☐ Interpreting Data to Make Decisions
- ☐ Comparing/Contrasting Ideas of Objects
- ☐ Perceptual Discrimination
- ☐ Other Specify:
- ☐ Predicting Events/Results
- ☐ Problem Solving
- ☐ Applying Knowledge
- ☐ Memory
- ☐ Other Specify:

☐ Academic Performance

- ☐ Oral Expression
- ☐ Written Expression
- ☐ Reading Comprehension
- ☐ Mathematics Calculation
- ☐ Other Specify:
- ☐ Listening Comprehension
- ☐ Basic Reading Skills
- ☐ Reading Fluency
- ☐ Mathematics Reasoning and Application
- ☐ Other Specify:

☐ Social Competence

- ☐ Interaction with Peers
- ☐ Interaction with Adults
- ☐ Acceptance of Rules
- ☐ Acceptance of Correction
- ☐ Acceptance to Disappointment
- ☐ Self Help Skills/Play Skills
- ☐ Team/Membership
- ☐ Other Specify:
- ☐ Mood Swings
- ☐ Repetative Behaviors
- ☐ Self Concept
- ☐ Inactivity or Withdrawal
- ☐ Cooperation
- ☐ Self Control
- ☐ Expression of Feelings/Affect
- ☐ Other Specify:

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☐ Communication

- ☐ Communicates Basic Needs and Wants
- ☐ Articulation
- ☐ Knowledge of Sound/Letter Association
- ☐ Other Specify:
- ☐ Expressive Language
- ☐ Voice Quality
- ☐ Receptive Language
- ☐ Other Specify:

☐ Work Skills/Technical/Vocational Functioning

- ☐ Attending to Task
- ☐ Following Directions
- ☐ Independent Work Habits
- ☐ Seeking Assistance When Needed
- ☐ Using Research Tools Effectively
- ☐ Maintaining Physical Stamina
- ☐ Having Realistic Vocational Goals
- ☐ Other Specify
- ☐ Punctuality
- ☐ Completing Work
- ☐ Organizing Materials/Belongings
- ☐ Using Technology to Gather/Organize Info
- ☐ Identifying Preferences/Interests
- ☐ Recognizing Personal Limitations
- ☐ Other Specify

☐ Physical

- ☐ Gross Motor Skills
  - ☐ Body Control
  - ☐ Locomotion
- ☐ Vision
- ☐ Developmental History
- ☐ Other Specify
- ☐ Fine Motor Skills
  - ☐ Perceptual Motor
  - ☐ Sensory
- ☐ Hearing
- ☐ Other Specify

Specialized Equipment Used by Student:		

School Information:
Number of Schools Attended to date:

School Name:					
Year and Grade:					
Number of Absences	Excused				
	Unexcused				
Disciplinary Concerns	Behaviors Noted				
	Suspensions				

Student Attend:	Additional Information:	Repeated Grades:
__ Pre-Kindergarten __ Head Start		

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Summary of Most Recent Grades (Provide Current or Most Recent Grades the Student Received by Content):

Reading		English		Other		
Spelling		Science		Other		
Math		Social Studies		Other		

Summary of Standardized Group Test Data (Attach copies):

Achievement:	Test Name:		Date:
Reading	Math	Language	Spelling

Physical Functioning:

Attach documentation for results of each screening.

VISION	**HEARING**
Required for all students referred for possible special education	
Date: ☐ Passed ☐ Failed	Date: ☐ Passed ☐ Failed

Academic Comments by Teacher

Behavior Comments by Teacher

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Student Name: ______________________ Date of Birth: ______________________

Summary of Past and Present Support:

Has this student been evaluated for special education previously? ☐ Yes ☐ No

If yes,
- When was the student evaluated?
- What was the suspected area of disability?

What services is this student receiving or what services has this student received in the past? For the services below, Enter **[C]** if currently receiving or **[P]** if the service was provided in the past

Limited English Proficient	RtI	Title 1	Speech Language	504	After School Tutoring	Counseling

Involvement with Outside Agency(ies): ☐ Yes ☐ No Agency:

Describe services that are being provided to this student by agency(ies) listed above:

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INTERVENTION STRATEGIES

Name:	DOB:	School Year:
Grade Level:	Teacher:	
School:		

Documentation of Student Progress (Scores from District Universal Screenings):

Test Name:			
Reading:	Math:	Language:	Behavior:
Date:	Date:	Date:	Date:
Test Name:			
Reading:	Math:	Language:	Behavior:
Date:	Date:	Date:	Date:

Interventions Implemented: (Documentation of Progress Data Must be Attached)

Targeted Area	Strategies/Interventions	Start Date	End Date	Impact on Targeted Area

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Student Name: ______________________ Date of Birth: ______________________

Health History

Pregnancy:

- ☐ Health Problems ______________________
- ☐ Medication Used ______________________
- ☐ Illnesses ______________________
- ☐ Falls or other accidents ______________________

Labor/Delivery:

☐ Full Term	☐ Pre-Mature ___mos.	☐ Post-Term ___mos.	☐ Cesarean
☐ Sudden	☐ Jaundice	☐ Meconium Stain	☐ Breech
☐ Induced	☐ Oxygen	☐ Breathing Issues	☐ Difficult
☐ Forceps	☐ Low Birth Weight	☐ Cyanosis (Blue Baby)	☐ Prolonged
☐ Vacuum	☐ Other ______________________		

Weight____lbs. _____oz.

- ☐ Injuries at/during Birth ______________________
- ☐ Needed medical attention and/or hospitalization required after delivery_________

____

Developmental Milestones:

Age of walking__________________ Age talked using words________________

Age when toilet trained __________ Age said sentences__________________

Hand dominance ___ Right ___ Left

Hospitalizations:

____

____

Medical/Psychiatric Diagnosis (es)

Diagnosis ______________________Age of diagnosis______________________

Diagnosis______________________ Age of diagnosis ______________________

Child's current state of health? _____Excellent _____Good _____Fair _____Poor

Student Name: ______________________ Date of Birth: ________________________

School Based Information:

What academic problems, if any, do you feel your child is having? __________________
____

What is your child's attitude towards school? ____________________________________
____

Home Based Information:

Please list all individuals living in your household (include name, age, and relationship to student)____
____

Forms of reinforcement/punishment used in the home? ___________________________
____
____

What does your child do at home in his/her free time? ___________________________
____

Describe your child's personality. (Include strengths) ____________________________
____

Have you noticed your child being different from others his/her age in development, achievement, or socialization? _____Yes _____No If yes, please explain. _____________
____

Present concerns/conditions:

- ☐ Attention Difficulties
- ☐ Hyperactivity
- ☐ Anxiety
- ☐ Depressed Mood
- ☐ Oppositional/Defiant
- ☐ Sleeping Problems
- ☐ Toileting Problems
- ☐ Eating Problems

Medication taken , if any, by the student ____________________________________

Describe any traumatic experiences that may pertain to his/her educational and/or emotional development. ____
____
____