Educational Support Team - Evaluation, Planning & Permission Process

Step 1 of 5: Request for Assessment, Page 1 of 1

Student _____ Completed by _____ Date _____

Teacher(s) or parent(s) requesting assessment:_____

Reason for request (i.e., developmental insight needed, or areas where student is having difficulty):

_____

_____

_____

_____

_____

What have you already tried in the classroom to address this?

_____

_____

Assessment(s) requested – check all that apply:

___ Developmental/Extra Lesson ___ Reading & Writing ___ Math ___ Therapeutic Eurythmy

___ Other: _____

(note: most assessments are done during class time)

Class Teacher approval:_____ Date:_____

PARENTS APPROVE

I/we have been informed of the aims and methods of the Educational Support Team and give permission for the above assessment(s).

Parent signature(s)

_____

_____

Date:_____

PARENTS DECLINE

I/we have been informed of the aims and methods of the Educational Support Team and decline permission for the above assessment(s).

Parent signature(s)

_____

_____

Date:_____

Step 2 of 5: Request for Support Services, Page 1 of 2

Student _____ Completed by _____ Date _____

Teacher(s) and/or parents requesting:

_____

SECTION 1

Teacher or parent to describe goals/challenges to be addressed:

_____

_____

_____

_____

_____

_____

_____

Program request – check all that may apply:

___ Developmental - Extra Lesson

___ Therapeutic Eurythmy

___ Reading/Writing Support

___ Math Support

___ Exemption from Standard Curriculum Requirements (see Step 5, page 2)

Do you feel this student's challenges are primarily (check one or number in order):

___ Organic/medical/constitutional

___ Emotional/psychological

___ Developmental

___ Needs more repetition for skills

Has this student been evaluated by an outside source, e.g. psychologist or district?

___ Yes ___ No

If Yes, attach copy of all reports

SECTION 2

To be completed by Class Teacher. Indicate your observations of challenges. 1 = no problem, 5 = significant difficulty

	1	2	3	4	5
Reading	○	○	○	○	○
Writing	○	○	○	○	○
Spelling	○	○	○	○	○
Math	○	○	○	○	○
Hearing	○	○	○	○	○
Speech	○	○	○	○	○
Form drawing	○	○	○	○	○
Memory	○	○	○	○	○
Will forces - i.e. easily discouraged	○	○	○	○	○
Reverses letters/numbers	○	○	○	○	○
Moves paper or torso to side	○	○	○	○	○
Writes bottom-up	○	○	○	○	○
Sequencing & Rhythm	○	○	○	○	○
Other classroom:	○	○	○	○	○
Physical Limitations or Handicap	○	○	○	○	○
Fine Motor/Eye-Hand	○	○	○	○	○
Laterality - i.e. switches hand use	○	○	○	○	○
Touch Sense - e.g. collisions or avoidance	○	○	○	○	○
Life Sense - e.g. often tired or can't hold thoughts	○	○	○	○	○
Movement Sense/Gross Motor - e.g. clumsiness	○	○	○	○	○
Balance Sense - e.g. trouble sitting still	○	○	○	○	○
Disruptive Behavior, Anxious or Nervous	○	○	○	○	○
Socialization	○	○	○	○	○
Body Awareness/Geography	○	○	○	○	○
Orientation in Time	○	○	○	○	○
Orientation in Space	○	○	○	○	○
Other:	○	○	○	○	○

SECTION 3

What has been done at school and home to address the student needs described on the front side? Please provide a brief history of this challenge.

Any other notes about this?

Please attach copies of Mid-Year and/or Year End Reports reflecting the student need.

Step 3 of 5: Inventory of Readiness for Classroom Tasks, Page 1 of 2

Student _____ Completed by _____ Date _____

(1 = no problem, 5 = significant difficulty)	1	2	3	4	5
Constitutional observations					
Unusual diet, e.g. a lot of soft foods, or refusal of an entire category of foods; strong aversion to some common textures, tastes or smells	○	○	○	○	○
Mouth breathing	○	○	○	○	○
Allergies, asthma	○	○	○	○	○
Appears physically immature	○	○	○	○	○
Seems over- or under- stimulated (circle one)	○	○	○	○	○
Lost on a cloud, or over-aware of environment (circle one)	○	○	○	○	○
Tired, sickly, stubborn, nervous (circle as applicable)	○	○	○	○	○
Other					
Behavior observations					
Quick to feel attacked/bothered, e.g. when in line	○	○	○	○	○
Avoids eye contact	○	○	○	○	○
Seeks excessive physical contact; or avoids physical contact (circle one)	○	○	○	○	○
Hesitation or refusal to participate in group activities	○	○	○	○	○
Slow with tasks or work; reluctant to move to next activity; fixates	○	○	○	○	○
Rushes ahead with tasks or work; difficulty with transitions	○	○	○	○	○
Trouble with spoken directions, multi-step directions	○	○	○	○	○
Trouble with written, drawn or moved directions	○	○	○	○	○
Other					
Movement observations					
Falls off chair	○	○	○	○	○
Tucks feet under legs or twists around chair	○	○	○	○	○
Twirls body	○	○	○	○	○
Makes noises or twitches	○	○	○	○	○
Fidgets, plays with objects	○	○	○	○	○
Clumsy	○	○	○	○	○
Difficulty or avoidance of personal care items like shoe tieing	○	○	○	○	○
Itching, picking	○	○	○	○	○
Soft speech or baby talk	○	○	○	○	○
Messiness - work or clothes, desk, etc.	○	○	○	○	○
Uncertain laterality; switches hand use	○	○	○	○	○
Tries to shake hands with left hand	○	○	○	○	○
Movements appear immature, i.e. toddler-like movements	○	○	○	○	○
Mirrors movements (3rd Gr. & up) i.e. uses left hand when you hold up right	○	○	○	○	○
Can't stay in rhythm or tone with marching, clapping, singing	○	○	○	○	○
Other					

(1 = no problem, 5 = significant difficulty)	1	2	3	4	5
Movement for reading and writing observations - Grades classroom					
Letter, number reversals	○	○	○	○	○
Tension or difficulty with pencil grip	○	○	○	○	○
Letter and/or number reversals	○	○	○	○	○
Messy or disorganized handwriting	○	○	○	○	○
Difficulty with form drawing	○	○	○	○	○
Holds reading close to eyes, or leans way in to desk work	○	○	○	○	○
Moves work or torso to one side so work is only on one side (which:)	○	○	○	○	○
Rubs eyes, blinks, frowns, tires quickly with eye tasks or gets headaches	○	○	○	○	○
Other					
Language observations - Early Childhood (or Grades)					
Home background for vocabulary, talking	○	○	○	○	○
Family background of dyslexia	○	○	○	○	○
Does not talk in complete sentences	○	○	○	○	○
Auditory discrimination, hearing	○	○	○	○	○
Poor grasp of concept of same/different, e.g. bigger/smaller, longer/shorter, older/younger	○	○	○	○	○
Does not listen to stories	○	○	○	○	○
Does not desire to understand stories; can't recall	○	○	○	○	○
Seems uninterested in books	○	○	○	○	○
Does not engage in dramatic play	○	○	○	○	○
Other					
Capacity observations - Grades (or Early Childhood)					
Questions re general intelligence	○	○	○	○	○
Emotional problems	○	○	○	○	○
Manifests fear, dislike or frustration about writing/reading activities	○	○	○	○	○
Feels like a failure at writing/reading activities, or overly awake to ability comparisons	○	○	○	○	○
Manifests fear, dislike or frustration about math/numeracy activities	○	○	○	○	○
Feels like a failure at math/numeracy activities, or overly awake to ability comparisons	○	○	○	○	○
Parents not with program - too much pressure	○	○	○	○	○
Parents not with program - too little expectation	○	○	○	○	○
Disparity in ability levels, i.e. any inconsistency such as emotionally awake but moves like a toddler, OR much brighter in math than reading or vice versa, verbal but not reading (note below)	○	○	○	○	○
Marked interest in mechanical objects, taking things apart	○	○	○	○	○
Asks a lot of questions, or none	○	○	○	○	○
Needs directions repeated many times	○	○	○	○	○
Other					

Step 4 of 5: Developmental/sensorimotor and learning needs history, Page 1 of 3

Student _____ Completed by _____ Date _____

Current Grade: _____ Date of Birth: _____

The following optional information can help the Educational Support Team develop a more complete picture of your child from early infancy to his/her present developmental stage. This form will not be added to your student's main file; it will be kept in his or her working file by the EST and shredded after your child departs AWS. Please complete information that you feel is important and that you're comfortable sharing.

PREGNANCY AND INFANCY

CURRENT HEALTH and HOME SETTING

Please describe any current home or health conditions which may affect learning; if child is on routine medication; any history of learning disabilities (student or family); social problems, etc.

Childhood

Please think of the various stages of your child's development, considering behavior that comes to mind as you answer these questions. Which behavior do you think of as being different from other children you know? Were there times when your child's behavior was difficult to cope with in the family unit? Circle the choice which applies: – Y (Yes), N (No), U (Used to), or D (Doesn't apply because child is not yet old enough, or for another reason).

Tactile (touch) – Did/does your child:

Dislike to be touched, held or cuddled??	Y N U D
Seem easily irritated or threatened when touched by siblings or playmates?	Y N U D
Have a strong need to touch people & objects?	Y N U D
Pinch, bite or otherwise hurt self or others?	Y N U D
Dislike the feeling of certain clothing?	Y N U D
Over or under dress for the temperature?	Y N U D
Other touch/sensory issues	

Vestibular (movement) – Did/does your child:

Enjoy being rocked, tossed in air, etc.	Y N U D
Like fast rides?	Y N U D
Like to swing?	Y N U D
Spin or whirl more than other children?	Y N U D
Get carsick easily?	Y N U D
Get nauseous and/or vomit from other kinds of movement?	Y N U D
Have fear in space (stairs, heights)?	Y N U D
Lose balance easily?	Y N U D
Walk on toes (not whole foot)?	Y N U D

Visual – Does your child:

Have a visual problem?	Y N U D
Seem very sensitive to light?	Y N U D
Have trouble using eyes?	Y N U D
Avoid eye contact?	Y N U D
Get distracted by visual stimuli?	Y N U D
Make reversals when writing, copying or reading?	Y N U D
Have trouble with shapes, colors and/or size?	Y N U D
Squint often?	Y N U D

Taste and Smell – Does your child:

Explore with taste?	Y N U D
Chew on non-food items?	Y N U D
Have any feeding problems?	Y N U D
Have trouble changing food textures?	Y N U D
Seem hypersensitive to smells?	Y N U D

Auditory & speech (sound)– Does/is your child:

Have a hearing loss?	Y N U D
Have PE tubes?	Y N U D
Have a lot of ear infections?	Y N U D
Hypersensitive to sounds?	Y N U D
Fear unexpected noises or unusual sounds?	Y N U D
Distracted by sound?	Y N U D
Miss sounds or words?	Y N U D
Have trouble listening?	Y N U D
Hum or make odd noises?	Y N U D
Have trouble imitating rhythmic sounds?	Y N U D
Have trouble understanding or following directions?	Y N U D
Talk or make noises excessively?	Y N U D
Talking interferes with listening?	Y N U D
Have delayed speech development?	Y N U D

Muscle Tone – Does your child:

Feel heavier than he/she looks?	Y N U D
Have good endurance?	Y N U D
Have muscle problems?	Y N U D
Have flat feet?	Y N U D
Slump when sitting?	Y N U D
Get tired easily?	Y N U D
Seem weak?	Y N U D

Coordination – Did/does your child:

Sit, stand or walk late?	Y N U D
Sit, stand or walk early?	Y N U D
Have a short creeping or crawling phase (or none at all)?	Y N U D
Have a very long creeping or crawling phase?	Y N U D
Creep on tummy or bottom?	Y N U D
Have slow, plodding, deliberate movements?	Y N U D
Play with toys appropriately for his/her age?	Y N U D
Have trouble dressing, buttoning, zipping and/or tying shoes?	Y N U D
Have trouble holding a pencil correctly?	Y N U D
Trip or fall a lot? Seem awkward?	Y N U D
Which hand is dominant?	R L
Have poor handwriting?	Y N U D
Handle small things easily?	Y N U D
Eat neatly for his/her age?	Y N U D
Have rigid movements?	Y N U D
Grimace or use tongue when performing fine motor tasks?	Y N U D
Like sports, PE, etc.?	Y N U D

Behavior/Temperament – Is/was your child:

An irritable baby?	Y N U D
Quiet, calm, patient?	Y N U D
Active, outgoing?	Y N U D
Intense, anxious?	Y N U D
Explosive, aggressive?	Y N U D
Easy going, predictable?	Y N U D
Clingy?	Y N U D
Rigid, set in ways?	Y N U D
Adaptable/flexible?	Y N U D
Distractible?	Y N U D
Moody?	Y N U D
Frustrated frequently?	Y N U D
Difficult to get to sleep?	Y N U D
Destructive with toys?	Y N U D

Did/does your child:

Have a high activity level?	Y N U D
Have a low activity level?	Y N U D
Have erratic sleep patterns?	Y N U D
Wet the bed? How often:	Y N U D
Wake frequently?	Y N U D
Have night terrors and/or nightmares?	Y N U D
Play well alone?	Y N U D
Have a short attention span?	Y N U D
Find it hard to make choices?	Y N U D
Dislike schedule changes or surprises?	Y N U D
Demonstrate self-stimulation behaviors?	Y N U D
Anger easily or have frequent tantrums?	Y N U D
Have difficulty with change?	Y N U D
Act out?	Y N U D
Make friends easily?	Y N U D
Prefer older children?	Y N U D
Prefer adults?	Y N U D
Prefer being alone?	Y N U D
Have low self-esteem?	Y N U D
Seem discouraged or depressed?	Y N U D

Learning Styles – Does your child:

Recognize own errors?	Y N U D
Learn from mistakes?	Y N U D
Acquire materials for tasks independently?	Y N U D
Set up his/her own workspace?	Y N U D
Maintain his/her workspace?	Y N U D
Work independently?	Y N U D
Generalize known skills to new ones?	Y N U D
Have age-appropriate memory?	Y N U D
Ask for help when necessary?	Y N U D
Plan ahead?	Y N U D
Create new ideas and/or new ways of doing things?	Y N U D
Use age-appropriate content in written language?	Y N U D
Get work done on time?	Y N U D
Perform at or above an average reading level?	Y N U D
Perform at or above an average math level?	Y N U D

Adapted from "Sensorimotor History" form by Patti Oetter MA, OTR 9/86 (which was adapted from A. J. Ayres, PhD; Patricia Wilbarger MED, OTR; Montgomery/Richter, 1977; B. Knickerbocker, OTR; Jo Murphy Hyland, OTR)

School history

Has your child ever received any screening or evaluation for learning support needs, been given a 504 Plan or an IEP, or needed regular tutoring to move ahead in school? If so, please provide dates and details. Y N

Please add anything else that will help us better educate your child

Step 5 of 5: Support Services Description and Permission , Page 1 of 2

Student _____ Completed by _____ Date _____

Teacher(s) recommending support program:_____

Academic area(s) indicating need for support:_____

Aims and schedule for program: _____

_____

_____

_____

_____

_____

Program will include the following as needed during this school year:

__ Extra Lesson __ Therapeutic Eurythmy __ Reading/Writing Support __ Math Support

Outside resources recommended _____

___ Homework required to support above. **HOMEWORK POLICY:** Your child will be helped with many exercises during school hours, but in order for him or her to progress, certain activities need to be done more frequently or for a longer time than is available during school. Therefore, our homework assignments are not a "wish list" or a beneficial extra, but ***a key component of your child's school program.***

Lesson schedule/classes to be excused from (see next page for any modification of requirements): _____

_____

_____

_____

PARENTS APPROVE

I/we have been informed of the aims and methods of the Educational Support Team and give permission for the above program, and will carry out the home requirements noted.

Parent signature(s)

_____

_____

Date:_____

PARENTS DECLINE

I/we have been informed of the aims and methods of the Educational Support Team and decline permission for the above program.

Parent signature(s)

_____

_____

Date:_____

EXEMPTION FROM STANDARD CURRICULUM REQUIREMENTS

Teacher(s) or parents requesting:

Basis* for request:

Aspects of Curriculum to be Modified or Exempted:

Duration of modification:

Alternate activity will be:

* Note: Program modifications may require a Physician's letter (in the case of a medical limitation) or a completed Educational/Psychological Assessment from the student's public school district or outside clinic.