Tier 1 Classroom Intervention

Student Name:_____ID#_____

DOB:_____Grade Level:____Teacher: _____

Campus:_____

Person making request: _____

☐ Parent ☐ Teacher ☐ Other: _____

Name of Parent or Guardian_____

Telephone: Home_____ Cell: Mother_____

Cell: Father_____ Work: Mother_____

Parent Contacted: ☐ Yes ☐ No Father _____

Parent/Guardian contact ☐ Phone call ☐ Note home ☐ Conference

Date of Parent Contact	Summary of Discussion	Comments/Concerns

*Attach a copy of the Nurse's Form

Referral Concern: _____Behavior _____Academic _____Speech

Specific Academic Concern

__Basic Reading __Math Calculation __Listening Comprehension __Written Expression

__Math Problem Solving __Oral Expression __Reading Fluency __Reading Comprehension

Reading Concerns should address one of the 5 components of reading:

1) Phonemic Awareness 2) Phonetics 3) Vocabulary 4) Fluency 5) Comprehension

Math Concerns should address one of the 5 areas of math:

1) Operations 2) Patterns 3) Geometry 4) Measurement 5) Probability 6) Problem Solving

Areas of Concern
Reading:

*Examples: Benchmark scores, TAKS scores, STAR Reading, DRA 2, EDL 2, Observation Survey

Math:

Universal Screener/Specific Skill	Date of Screening	Results of Screening	Current Performance

Accommodations

Accommodations	Circle One				How Often			
Reading or Math (Circle One)	Successful	Unsuccessful	Not Tried	Not Applicable	Daily	Weekly	Date Begun	Date Ended
☐ Teacher-led small groups	S	US	NT	NA				
☐ Change seating	S	US	NT	NA				
☐ Reduce distractions	S	US	NT	NA				
☐ Provide breaks	S	US	NT	NA				
☐ Use visual cues	S	US	NT	NA				
☐ Modify Instructions	S	US	NT	NA				
☐ Peer Tutor/Mentor	S	US	NT	NA				
☐ Allow more time	S	US	NT	NA				
☐ Give immediate feedback	S	US	NT	NA				
☐ Minimize Transition Time	S	US	NT	NA				
☐ Positive reinforcement	S	US	NT	NA				
☐ Use Timer	S	US	NT	NA				
☐ Break tasks into smaller steps								

Other accommodations tried:

_____

_____

_____

Provide documentation (i.e. weekly test, running records ect.)

***Examples: Benchmark scores, TAKS scores, STAR Reading, DRA 2, EDL 2, Observation Survey**

I verify that the above accommodations were conducted as described and documentation is provided.

Completed by:_____ Date: _____

*Examples: Benchmark scores, TAKS scores, STAR Reading, DRA 2, EDL 2, Observation Survey

GOOSE CREEK CISD — Nurse Information Form

Student:		Gender:		Campus:		Grade:	
DOB:		Age:		Teacher:		School Year:	

Vision Screening Results: ***Results must be current (within one calendar year)**

Name of person conducting screening: _____ Position:____ School Nurse ____ other

Date of Screening: _____/_____/_____ Screening: _____without glasses _____lost _____ broken
_____with glasses/contacts

Type of Screening: _____ Snellen E @_____ 10 feet or _____ 20 feet
_____ Snellen Letter @_____ 10 feet or _____ 20 feet
_____ HOTV

Acuity Results - Right eye: _____ Left eye: _____

Results of Screening: _____ Passed _____ Failed
Referred for follow up treatment: _____ Date: _____

Hearing Screening Results: ***Results must be current (within one calendar year)**

Name of person conducting screening: _____ Position:____ School Nurse ____ Other
Date of Screening: _____/_____/_____

Puretone Audiometer Screening: _____Yes _____ No

Ear	1000 Hz	2000 Hz	4000 Hz
Right			
Left			

Results of Screening: _____ Passed_____ Failed
Referred for follow up treatment: _____ Date: _____

Other School Health Medical Information:

Does the student require other ongoing health services such as those listed below? _____Yes _____No
_____ special prescribed diets _____ catheterization _____ monitoring use of wheelchair, crutches, etc.
_____ special feeding procedures _____ monitoring of seizures _____ prescribed rest periods
_____ other:_____

_____ Yes _____ No Does student have any life threatening allergies requiring an Epinephrine auto-injector?
If yes explain,

_____

_____ Yes _____ No Does student have a history of frequent illness/complaints that necessitate clinic visits?

_____

_____ Yes _____ No To your knowledge, is the student under a doctor's care? For what reason(s)?

_____

Does the student take prescribed medication _____at school _____at home that the school nurse is aware of?

If yes, for what reason(s)? _____

Comments: _____

Signature_____ Date Completed_____