

IV

FORMS

ACKNOWLEDGEMENT OF ASSESSMENT RESULTS

(Level B Assessment, Speech-Language Assessment,
School Psychology Assessment/Consultation)

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

I acknowledge the receipt of these _____ results dated _____
(Type of Assessment)

I acknowledge that these results will be filed in _____
(Name of Student)
Special Documents Envelope (SDE).

Signature of Parent

Date

Address

Results of the assessment were shared with _____ on _____
Date

Signature of Assessor

Date

PLEASE NOTE: Parents may file a response to the results if they so desire. This response will be attached to the original report.

Original to Special Documents Envelope (SDE)
Copy to Assessor



ASSESSMENT REPORT - LEVEL B

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

Date Referred from Program Planning Team: _____

Date of Test Administration: _____

Date of Report: _____

Name of Qualified Test Administrator: _____

Test(s) Administered: _____

Background Information: _____

Testing Behaviour: _____

Test Results/Comments: _____

Summary: _____

Recommendations/Suggestions: _____

_____	_____
Assessor Signature	Date
_____	_____
Consultant/Coordinator Signature	Date

Original to Authorized Location (see page 16)
Copy to Special Documents Envelope (SDE)
Copy to Parent/Guardian



AUTHORIZATION AND RELEASE OF RECORDS FORM

I, _____ of _____
(Full Name of Parent/Guardian) (Parent/Guardian Address)

(Parent/Guardian Address)

hereby give permission for the Tri-County Regional School Board to release and/or obtain all pertinent information and reports regarding _____,

(Student Name)

(Tri-County School)

(Date of Birth: Y ___ M ___ D ___)

Check appropriate box and initial

- _____ Authorization to consult with appropriate school staff regarding an individual student
- _____ Authorization to observe an individual student in a school setting
- _____ Authorization to meet privately with an individual student
- _____ Authorization to review an individual student record with qualified Tri-County Regional School Board staff

between:

TRI-COUNTY REGIONAL SCHOOL BOARD
Attention: Coordinator of Student Services
79 Water Street
Yarmouth, Nova Scotia
B5A 1L4

and

Name/Institution: _____

Mailing Address: _____

Postal Code: _____

Special Instructions: _____

Parent/Guardian Signature

Signature of Witness

Date

Original to Special Documents Envelope (SDE)

BEHAVIOUR MANAGEMENT PLAN

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

Implementation Date: _____

Review Dates: (4-6 weeks following implementation)

Date: _____ **Parent/Guardian Initial:** _____

Date: _____ **Parent/Guardian Initial:** _____

Individuals Involved in Developing the Behaviour Management Plan:

Summary Of:	Strengths:	Needs:
Academic/Cognitive		
Communication (expressive/receptive)		
Social/Behavioural		
Physical/Motor		

General Behavioural Needs:

Context of Behaviour (ie. Possible contributing factors):

Previously Implemented Interventions: (please be specific: ie. Behaviour contract, reward systems, etc.)

.....continued

Behavioural Goal:

Specific Objectives	Materials	Teaching Strategies for Desired Behaviour	Description of Consequences		Progress/Date
			Positive	Negative	

How will the Behaviour management plan be evaluated?

- | | | |
|---|---|---|
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Student Report | <input type="checkbox"/> Communication Log |
| <input type="checkbox"/> Teacher Report | <input type="checkbox"/> Academic Achievement | <input type="checkbox"/> Behaviour Tracking Forms |
| <input type="checkbox"/> Other (explain): _____ | | |

Review Date (4-6 weeks following implementation): _____

Person(s) Responsible:

Crisis Management Plan (if applicable)

TRANSITION PLAN

Moving from: _____ **to** _____
(school program) (school program)

Meeting Dates: _____

Transition Team Members: (sending and receiving)

Sending Team Members

Receiving Team Members

Special Arrangements: (materials, equipment, medication etc.)

- | | |
|---|---|
| <input type="checkbox"/> Tour Facility | <input type="checkbox"/> Transfer of Equipment |
| <input type="checkbox"/> Bussing/Conveyance | <input type="checkbox"/> Professional Staff On-Site Visit |
| <input type="checkbox"/> Orientation Day(s) | <input type="checkbox"/> Specialized Training |
| <input type="checkbox"/> Modification of Facilities | <input type="checkbox"/> Other: _____ |

Long Term Transition Goal:

Annual Outcome:

Specific Outcomes	Supports/Materials	Person(s) Responsible	Time Line

Parent/Guardian Initial:

<input type="checkbox"/> I agree with the Behaviour Management Plan	<input type="checkbox"/> I disagree with the Behaviour Management Plan
_____ Parent/Guardian Signature	_____ Date

Signatures:

Teacher Signature	Date
Teacher Signature	Date
Teacher Signature	Date
Principal Signature	Date

Original to Cumulative Record Folder
Copy to Signatories



TUTOR APPLICATION FORM

To be completed by School Program Planning Team.

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

Reason for application (please check one):

Medical: Out of School :

If medical, Form 5B "Tutor-Medical Recommendation" must be completed and attached.

Supporting information: _____

Type of service recommended: _____

Amount of service recommended: _____

Chair Program Planning Team

Date

Principal

Date

Approved Services _____	
_____ Superintendent	Approved <input type="checkbox"/> Not approved <input type="checkbox"/>

Forward to Superintendent
Signed Copy to Special Documents Envelope



TUTOR-MEDICAL RECOMMENDATION FORM

Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Parent/Guardian Name: _____	Contact No.: _____
Home Address: _____	
School: _____	Date: _____
School Address: _____	
Principal: _____	Contact No.: _____

To be completed by a medical doctor and returned to school principal.

Medical History: _____

In your medical opinion is this child/youth able to attend school (please check one):

Full time: Part time: Not at all:

If your answer to the above is "Full or Part time" what modifications, if any, are needed for the child to attend school? _____

If your answer to the above is "Not at all" please explain why. _____

How long do you anticipate this student being out of public school? _____

Physician's Name: _____

_____ Signature of Physician	_____ Date
---------------------------------	---------------

TUTOR INFORMATION FORM

IMPORTANT: Attach a Data Activation Sheet

Please check the appropriate box:

- Medical Tutor
- Out of School Tutor

TUTOR INFORMATION

Name of tutor: _____ **Telephone:** _____

Mailing Address: _____

Postal Code: _____ **E-mail:** _____

*Complete all attached data forms (Data Activation Sheet, RCMP/Child Abuse Check)
Once approved, weekly time cards will have to be forwarded to Bridgewater for payment.*

STUDENT INFORMATION

Name of student: _____ **Grade:** _____

School: _____ **# of hours required per week:** _____

Parent/Guardian signature: _____

Forward to Coordinator of Student Services



INDIVIDUAL PROGRAM PLAN

PART 1

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B.(yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent's/Guardian's Name: _____	Contact No.: _____

Implementation Date: _____

Review Dates: _____ Parent/Guardian Initial: _____

_____ Parent/Guardian Initial: _____

Individual Program Planning Team Members:	Position:

Student Profile:

Description of Exceptionality

Assessments:	Date:

Summary Of:	Strengths:	Needs:
Academic/Cognitive		
Communication (expressive/receptive)		
Social/Behavioural		
Physical/Motor		

Services Provided:

Service	Provider	Time Per Day Cycle	Location

Arrangements: (materials, equipment, medication etc.)

Adaptations: (if applicable)

Parent/Guardian Initial: _____

.....continued 56

PART 2

ANNUAL OUTCOME

Specific Outcome		Strategies	Materials	Evaluation Methods	Personnel Responsible	Progress/Date Achieved
a)	___ will be expected to					
b)	___ will be expected to					

ANNUAL OUTCOME

Specific Outcome		Strategies	Materials	Evaluation Methods	Personnel Responsible	Progress/Date Achieved
a)	___ will be expected to					
b)	___ will be expected to					

ANNUAL OUTCOME

Specific Outcome		Strategies	Materials	Evaluation Methods	Personnel Responsible	Progress/Date Achieved
a)	___ will be expected to					
b)	___ will be expected to					

Parent/Guardian Initial:

.....continued

PART 3 – TRANSITION PLAN

Moving from: _____ **to** _____
 (school program) (school program)

Meeting Dates: _____

Transition Team Members: (sending and receiving)

Sending Team Members

Receiving Team Members

Special Arrangements: (materials, equipment, medication etc.)

- | | |
|---|---|
| <input type="checkbox"/> Tour Facility | <input type="checkbox"/> Transfer of Equipment |
| <input type="checkbox"/> Bussing/Conveyance | <input type="checkbox"/> Professional Staff On-Site Visit |
| <input type="checkbox"/> Orientation Day(s) | <input type="checkbox"/> Specialized Training |
| <input type="checkbox"/> Modification of Facilities | <input type="checkbox"/> Other: _____ |

Long Term Transition Goal:

Annual Outcome:

	Specific Outcomes	Supports/Materials	Person(s) Responsible	Time Line
a)	_____ will be expected to			
b)	_____ will be expected to			

Parent/Guardian Initial:

.....continued

All Individual Program Plan Courses (Grade 10, 11, 12) must be documented and attached to the transcript. All students including those on full Individual Program Plans must meet the 18 credit requirements for graduation diploma as outlined in the Public School Program.

- I agree with the Individual Program Plan
- I disagree with the Individual Program Plan

Parent /Guardian Signature

Date

Signatures:

Teacher Signature

Date

Teacher Signature

Date

Teacher Signature

Date

Principal Signature

Date

Review plan and attach recommendations.

**Original to Cumulative Record Folder
Copy to Signatories**



PARENT/GUARDIAN CONSENT FOR
LEVEL B ASSESSMENT

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B.(yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

I hereby give permission for _____ to be given an
Name of Student
individualized achievement assessment. I understand that school staff may be consulted and will receive
information regarding the results.

Parent/Guardian Signature

Date

Original to Special Documents Envelope (SDE)
Copy to Assessor
Copy attached to original report and protocol



PARENT/GUARDIAN CONSENT FOR
SUPPORT SERVICES

School: _____	Date: _____
Student Name: _____	D.O.B.(yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

Services Recommended by the School:

- Level A Assessment
- Resource Support

Please Complete:

I consent to _____ receiving the above indicated resource services.
Name of Student

Parent/Guardian Signature

Date

Note: Please follow Student Services Policies and Procedures regarding developing and implementing program plans for students with special needs.

Signature of Resource Teacher

Original to Cumulative Record Folder

**PARENT/GUARDIAN CONSENT
PSYCHOLOGICAL SERVICES**

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

Services(s) recommended by the School Program Planning Team:

- | | |
|--|---|
| <input type="checkbox"/> Formal Psycho-educational Assessment* | <input type="checkbox"/> Behavioural Consultation/Assessment* |
| <input type="checkbox"/> Counselling (Group/Individual)* | <input type="checkbox"/> Other: _____
_____ |

*Please see attached for descriptions of these services.

It is important for you and your child to understand that participation in the above activities is voluntary; your child cannot be required to participate. You and/or your child also have the right to discontinue the process at any time. If you decide to allow your child to participate, information on his/her participation will become a permanent part of your child's record.

Please Complete:

I consent to _____ receiving the above indicated service, and I understand that the
Name of Student
 involved school staff may be consulted, and that information about the referral may be placed in the student's Special Documents Envelope (SDE). I understand that this information will be discussed at Program Planning Team meetings and may be used to program for my child. In the case of an assessment, a written report would be placed in the student's Special Documents Envelope (SDE).

Parent/Guardian Signature

Date

I do not consent to _____ receiving the above indicated services. <small style="margin-left: 100px;">Name of Student</small>	
_____ Parent/Guardian Signature	_____ Date

Original to Special Documents Envelope (SDE)

.....continued
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***What is involved in a Psycho-educational assessment?**

An individual Psycho-educational assessment completed by a School Psychologist will include the use of tests, observations, and discussions with the student in a one-to-one situation at the school. Depending on the referral, the assessment may address intellectual, developmental, academic and/or social-emotional tests and concerns. An assessment may include a review of school history, classroom observations, as well as interviews with the student, parent(s) or guardian(s), school personnel, and outside agencies such as family physicians and/or community services. Discussions with school staff and a review of all student records are involved. The parents/guardians will be asked to provide information about their child. Meetings with the Program Planning Team (including the parents/guardians and/or student) to review the results and clarify information will occur once the assessment is completed. The written report completed by the School Psychologist is placed in the student's Special Documents Envelope and a copy is provided to the parent/guardian.

***What is involved in counselling?**

Counselling services can often help students cope with life experiences that are impacting on their ability to perform to their potential. Conversations between the student and the psychologist are protected under confidentiality. However, the goal of all counselling services is to promote student well-being and healthy communication between the student and the significant individuals in their lives. There are three instances when a psychologist is ethically bound to break a confidence: when there is harm to self or others, when there is suspected child abuse, and when there is a court order. This service would be provided by the School Psychologist. Counselling services offered at the school level are usually short-term.

***What is involved in a Behavioural Consultation/Assessment?**

Often, the behaviour of a student can have an impact on their ability to perform to their potential. Many times, a referral to the School Psychologist for a behavioural consultation/assessment may be needed. An assessment may include a review of school history, classroom observations, as well as interviews with the student, parent(s) or guardian(s), school personnel, and outside agencies such as family physicians and/or community services. Discussions with school staff and a review of all student records are involved. The parents/guardians will be asked to provide information about their child. Meetings with the Program Planning Team (including the parents/guardians and/or student) to review the results and clarify information will occur once the assessment is completed.

PARENT/GUARDIAN CONSENT FOR
THE SEVERE LEARNING DISABILITIES PROGRAM (SLD)

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

Your child has been selected to participate in the Severe Learning Disabilities program. The SLD teacher provides direct services to students enrolled in the program. This may involve in-class small group and/or individual support in alternate settings to strengthen your child's literacy and/or numeracy skills.

Please Complete:

I consent to _____ receiving the above services and I understand
Name of Student
 that school staff may be consulted, and will receive information regarding the results/services.

Parent/Guardian Signature Date

Original to Cumulative Record Folder
Copy to Severe Learning Disabilities Teacher

REFERRAL FOR SPEECH-LANGUAGE SERVICES

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

Date of referral: _____

Referred By: School Program Planning Team

Services Requested by School Program Planning Team:

- Assessment
- Consultation
- Screening

Reason for referral: _____

Child has also been referred to, or is being seen by:

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Resource |
| <input type="checkbox"/> Reading Recovery | <input type="checkbox"/> IWK |
| <input type="checkbox"/> Other (list) _____ | |

Child is on:

- Individual Program Plan
- Behaviour Management Plan
- Adaptations

Signature of Principal

Date

Signature of School Program Planning Team Chair

Date

Original to Special Documents Envelope (SDE)
Copy to SLP

.....continued

Student Name: _____

To be completed by the classroom teacher in consultation with the SLP.

Areas of Concern:

1. LANGUAGE (Check those that apply)

- Difficulty understanding oral language (i.e. following directions, understanding classroom discussion)
- Difficulty using oral language to express thoughts or ideas (i.e. limited vocabulary, poor grammar)
- Difficulty with phonological awareness skills (i.e. rhyme, sound/letter correspondence, segmenting, blending, spelling, decoding)

Date of last language assessment: _____

Discuss _____

2. ARTICULATION - Mispronounces one or more sound(s), difficult to understand by familiar people/strangers

Discuss _____

3. STUTTERING - Difficulty controlling the fluency and rate of speech. If stuttering is present, when was it first noticed. Does it increase or decrease in different situations/time of day?

Discuss _____

4. VOICE - Voice characteristics such as hoarseness, nasality, too low/high pitch. Does it change in different situations/time of day?

Discuss _____

5. HEARING - Known or suspected hearing loss Date of last hearing test: _____

Discuss _____

Signature of Classroom Teacher

Date

Signature of SLP

Date

Original to Special Documents Envelope (SDE)
Copy to SLP

.....continued

SPEECH-LANGUAGE CASE HISTORY FORM

To be completed by parent/guardian.

1. IDENTIFICATION

Name of person completing form: _____

Relationship to student: _____

Name of Child: _____ Date of Birth: _____

School and Grade: _____ Grade: _____

French Immersion: Yes No

Language(s) spoken at home: French English Other _____

2. SPEECH/LANGUAGE DEVELOPMENT

Areas of Concern:

(a) LANGUAGE (Check those that apply)

Difficulty understanding oral language (i.e. following directions, understanding classroom discussion)

Difficulty using oral language to express thoughts or ideas (i.e. limited vocabulary, poor grammar)

Difficulty with letter/sound awareness skills (i.e. rhyme, sound/letter correspondence, segmenting, blending, spelling, decoding)

Date of last language assessment: _____

Discuss _____

(b) ARTICULATION - Mispronounces one or more sound(s), difficult to understand by familiar people/strangers

Discuss _____

.....continued

- (c) **STUTTERING** - Difficulty controlling the fluency and rate of speech (i.e. stuttering). If stuttering is present, when was it first noticed. Does it increase or decrease in different situation/time of day?

Discuss _____

- (d) **VOICE** - Voice characteristics such as hoarseness, nasality, too low/high pitch. Does it change in different situations/time of day?

Discuss _____

- (e) **HEARING** - Known or suspected hearing loss

Date of last hearing test: _____

Discuss _____

	Earlier than range	Within expected expected	Later than expected
When did your child begin to use single words?	_____	_____	_____
When did your child begin to combine two words? (Expected range for single words: 12-18 months) (Expected range for 2 word combinations: by 24 months)	_____	_____	_____

Has your child ever been seen for speech-language or hearing evaluation/therapy? Yes No

If yes:

When _____

Where _____

Results _____

Are there family members who have speech/hearing problems ? (eg. parent, brother, sister, uncle, cousin, grandparent) Yes No

If yes, indicate relationship: _____

Describe Problem: _____

3. MEDICAL HISTORY

	Yes	Explain
Difficulties during Pregnancy	<input type="checkbox"/>	_____
Difficulties during Birth	<input type="checkbox"/>	_____
Birth Defect	<input type="checkbox"/>	_____
Ongoing Illness	<input type="checkbox"/>	_____
Been Hospitalized (If yes, please provide reason)	<input type="checkbox"/>	_____
Had Tubes in ears	<input type="checkbox"/>	_____
Being followed by an ENT (Ear, Nose, and Throat Specialist)? If yes, with whom and date of last appointment	<input type="checkbox"/>	_____
Seen by other health care professionals (i.e. Psychologist, Psychiatrist, Occupational Therapist,) If yes, with whom, and date of last Appointment	<input type="checkbox"/>	_____
Medication	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	_____
Hearing Problems	<input type="checkbox"/>	_____
Eating problems (chewing, swallowing, drooling)	<input type="checkbox"/>	_____

Additional information (hearing, vision, physical disability):

**Original to Special Documents Envelope (SDE)
Copy to SLP**



PARENT/GUARDIAN CONSENT FOR
SPEECH-LANGUAGE SERVICES

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

Services recommended by the school:

- Assessment
- Therapy
- Screening
- Consultation

Please complete:

I consent to _____ receiving the above indicated service(s).
Name of Student

Signature of Parent/Guardian

Date

Note: Please follow Student Services Policies and Procedures regarding developing and implementing program plans for students with special needs.

Signature of Speech-Language Pathologist

**Original to Cumulative Record Folder
Copy to S-LP**



ACKNOWLEDGEMENT OF DISCONTINUATION OF
SPEECH-LANGUAGE SERVICES

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

_____ is being discontinued from Speech-Language services as of
Name of Student

Date

Reason(s):

Outcome achieved	<input type="checkbox"/>	Lack of progress	<input type="checkbox"/>
Lack of Compliance	<input type="checkbox"/>	Parental Request	<input type="checkbox"/>

Other _____

I acknowledge the receipt of this discontinuation information and acknowledge that these recommendations will be filed in _____ CRF.
Name of Student

Signature of S-LP

Signature of Parent

Signature of Teacher

Signature of Teacher

Signature of Principal

Please Note: Parents may file a response to this if they so desire. This response will be attached to the original report.

**Original to CRF
Copy to SLP**

**PARENT/GUARDIAN CONSENT FOR
ADMINISTRATION OF MEDICATIONS/MEDICAL PROCEDURES**

Preamble

It is the Board's policy that under normal circumstances prescribed medication should be dispensed before and/or after school hours under the supervision of the parent.

Untrained staff and volunteers should not be involved in the administering of medications.

The Board considers it to be the responsibility of the parents to make arrangements to eliminate the need for school personnel being so involved.

Exception to the above policy statement (preamble):

If in the opinion of a practicing physician a particular student requires medication in order to attend school, and that medication by necessity must be taken during school hours, the Board has approved a set of procedures that must be implemented by the principal or designate.

To be completed by parent/guardian

Name of student: _____

Name of parents/guardians: _____

Phone (H) _____ (W) _____

Address: _____

Mailing Address: _____

School: _____ Grade: _____

Contact in case of emergency: _____ Phone: _____

I hereby request, authorize and empower the Tri-County Regional School Board to administer medication or treatment as described herein to my child named above. I release any staff member and the Tri-County Regional School Board from any legal liability that may result from the administration of such medication or the giving of such treatment. I also agree to indemnify the Tri-County Regional School Board against claims at any time made arising out of the administration of medication or treatment described herein by my child or MSI.

Signature of Parent/Guardian

Date

.....continued

To be completed by physician/pharmacist

Medical condition requiring treatment: _____

Medication Prescribed	Dose	Duration	Time of Admin.

Treatment	Procedure	Duration	Time

Other: _____

Possible side effects of medication(s)/treatment: _____

Type of storage required for medication: _____

Will it be detrimental to the child's health if a single dose/treatment is omitted? YES NO

Persons administering the medication/treatment as described above **do not need/do need** (please circle one) to have training to perform the procedure.

Signature of Attending Physician or Pharmacist

Phone No.

Date

Original to Special Documents Envelope



MEDICAL PLAN
SCHOOL YEAR: 20__ - 20__

Student Information (to be completed by the parent/guardian)

Student (Legal) Name: _____	D.O.B.(yy/mm/dd): _____
Medic Alert I.D.: _____	Health Card Number: _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____
Family Physician: _____	Telephone: _____

Medical Information (to be completed by parent/guardian)

Nature of disease/illness: _____

Symptoms of reaction: _____

Medication(s): This student must have the following prescription medication administered during the school day and/or in the event of an emergency:

Medication: _____

Dosage: _____

Prescribed by: _____

Method of administration (oral, injection etc.): _____

Administered by: _____

Additional instruction or information: _____

The following information is to be coordinated by the Principal

School commitments: _____

Parents/guardians commitments: _____

Outline of daily procedure: _____

EMERGENCY PLAN

First contact: _____ **at** _____

Alternate contact: _____ **at** _____

Steps to follow: _____

EVACUATION PROCEDURE: _____

Safe refuge * in the event of fire is located in _____

APPROVAL OF PLAN AND ASSOCIATED TRAINING ARRANGEMENTS

This Emergency/Medical Plan and the related training in required medical procedures are approved by the following parties:

Parent/Guardian: _____ Date: _____

Principal: _____ Date: _____

Family Doctor: _____ Date: _____

Other (Specify): _____ Date: _____

I hereby consent to this information being shared with the following. *(Check off appropriate boxes.)*

Transportation Staff (Bus Driver, Dispatcher etc....)

Appropriate School Staff (Teachers, Duty Aid, PSA etc...)

Parent/Guardian: _____ Date: _____

*The local fire department ***must be*** notified of the school's designated safe refuge area.

Original to Cumulative Record Folder
Copy to be stored in accessible location at school
Copy to Transportation Staff (if applicable)

ADAPTATIONS

Definition

Adaptations are prepared for a student when significant adaptations are required but the outcomes of the Public School Program remain the same.

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

Developed By: _____

Summary Of:	Strengths:	Needs:
Academic/Cognitive		
Communication (expressive/receptive)		
Social/Behavioural		
Physical/Motor		

Adaptations/Strategies and Personnel Responsible:

_____	_____
Parent/Guardian Signature	Date
_____	_____
Teacher Signature	Date
_____	_____
Teacher Signature	Date
_____	_____
Principal Signature	Date

Review plan and attach recommendations.

Original to Cumulative Record Folder
Copies to Signatories

PROGRAM PLANNING NOTES

- School Program Planning Team or
- Individual Program Planning Team
- Other

<p>Name of Student: _____ Grade: _____</p> <p>Date of Meeting/Time: _____ School: _____</p> <p>Person(s) Present: _____</p>
--

Discussion/Notes:

Action Items: (note person responsible and time line)

Signature of Principal

Date

**Original to Cumulative Record Folder or
Special Documents Envelope (SDE) if confidential information is recorded**

PROGRAM SUPPORT ASSISTANT (PSA)
APPLICATION

School Year: _____

School: _____

Background

Each school year, individual applications for all Program Support Assistants (PSAs) to assist with student programming must be filed by the school principal with Student Services Coordinator by April 1 for students currently enrolled and by May 1 for students enrolling in Grade Primary. Both pages of this form must be completed for each PSA request.

LEVEL OF SUPPORT REQUESTED: 1 FTE .5 FTE

PSA request for:

Student Name _____ **Grade (next academic year)** _____ **Age**

Level of Current Support: Full Time: Part Time: Shared:

Rationale for Request (list diagnosed disorders, syndromes, physical/medical conditions, etc.):

Student Name _____ **Grade (next academic year)** _____ **Age**

Level of Current Support: Full Time: Part Time: Shared:

Rationale for Request (list diagnosed disorders, syndromes, physical/medical conditions, etc.):

Student Name _____ **Grade (next academic year)** _____ **Age**

Level of Current Support: Full Time: Part Time: Shared:

Rationale for Request (list diagnosed disorders, syndromes, physical/medical conditions, etc.):

Student Name _____ **Grade (next academic year)** _____ **Age**

Level of Current Support: Full Time: Part Time: Shared:

Rationale for Request (list diagnosed disorders, syndromes, physical/medical conditions, etc.):

.....continued

Date of School Program Planning Team Meeting to Discuss PSA Need: _____

Members of School Program Planning Team Present:

How is this request related to each student’s program plan? (Please attach each student’s program plan)

Are there specific qualifications/experiences/skills/abilities required of this PSA?

All requests will be reviewed by a committee consisting of:

- Coordinator of Student Services
- Student Services Consultants
- Superintendent and/or Director of Programs and Student Services

Requests denied are subject to a review by way of the principal or designate appearing before the above committee.

A response to application requests will be responded to as promptly as budget deliberations and subsequent staffing permits.

Signature of Principal

Date

Original to Coordinator of Student Services



PROGRAM SUPPORT ASSISTANT (PSA)
REQUEST FOR EXTENDED HOURS

** Attach Employee's Data Activation and Change Sheet*

Reference: Article 6:08 S.E.I.U. Collective Agreement	
School: _____	
Student: _____	PSA: _____
Request: No. of Hours _____ days/week _____ duration _____	
Start Date: _____	End Date: _____

Rationale: _____

How is this request incorporated into the student's program plan? _____

Principal's Signature: _____ Date: _____

Principal's Comments: _____

Note: Please submit requests to the Coordinator of Student Services with signature. Submissions must not be faxed as confidential information could be contained in the report.

Signature of Coordinator of Student Services

Date

Signature of Superintendent

Date

Approved Not approved Reason: _____

**Original to Principal
Copy to Human Resources**



PROGRAM SUPPORT ASSISTANT (PSA)
CHANGE IN EXTENDED HOURS

* *Attach Employee's Data Activation and Change Sheet*

School: _____	
Student: _____	PSA: _____
Change in Extended Hours:	
Current No. of Hours _____	days/week _____
Change to No. of Hours _____	days/week _____
Start Date: _____	End Date: _____

Rationale: _____

Principal's Signature: _____ Date: _____

Note: Please submit requests to the Coordinator of Student Services with signature. Submissions must not be faxed as confidential information could be contained in the report.

Signature of Coordinator of Student Services

Date

Signature of Superintendent

Date

**Original to Principal
Copy to Human Resources**



RECORD OF ADMINISTRATION OF MEDICATION

Name of Student: _____ D.O.B.: _____

Name of Parent/Guardian: _____

Home Phone: _____ Work Phone: _____

Contact Name in Case of Emergency: _____ Emergency Phone #: _____

School: _____ Classroom Teacher: _____

Name of Physician: _____ Physician's Phone Number: _____

Caution:

In any case designated by the physician as being potentially life threatening, the staff member supervising medication administration must have a witness confirm the administration.

Delegated staff member: _____

Alternate staff member: _____

Date	Amount/Dose of Medication	Time Given	Staff Signature	Witness	Comment/Observations if Reaction is Unusual

This record should have Parent/Guardian, Consent for the Administration of Medications/Medical Procedures attached.



REFERRAL TO SCHOOL PROGRAM PLANNING TEAM

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

Referred By: _____ Date: _____

1. Briefly summarize what is of concern with this student:

2. What interventions and/or adaptations have been tried, and what successes and difficulties have resulted?

Intervention/Adaptation	Success	Difficulty

3. What specific request is being made regarding this student?

Original to Cumulative Record Folder with attached Program Planning Notes (Form 16) once School Program Planning Team Meeting has occurred.



REFERRAL FOR LEVEL B ASSESSMENT

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

Date of referral: _____

Referred by: School Program Planning Team

Reason for referral: _____

Previous testing (instruments and dates):

What classroom/school/program interventions have been tried to date?

- Adaptations (please attach current plan to this referral)
- Individual Program Plan (please attach current Individual Program Plan to this referral)
- Reading Recovery (outcome status: referred on or successfully discontinued)
- Literacy Support Plan reading writing
- Specialist Services: Speech-Language Guidance Alternate Program
 Other _____
- Resource/Learning Centre Support (explain: length of time, main focus, etc.)

- Classroom Strategies (Please list) _____

- Outside Agencies (Specify) _____
- Other _____

.....continued

Relevant History:

Signature of Principal

Date

Signature of School Program Planning Team Chair

Date

Original to Special Documents Envelope (SDE)
Copy to Assessor
Copy attached to original report and protocol



REFERRAL FOR SCHOOL
PSYCHOLOGICAL SERVICES

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

Date of Referral: _____

Referred by: School Program Planning Team

Nature of the concern(s)

- Academic
- Behavioural
- Social/Emotional
- Re-assessment
- Other _____

Reason for Referral: _____

Specific Service(s) being requested: _____

.....continued

Previous Testing (instruments and date):

Strengths

Areas of Concern

Briefly outline the student's performance (i.e. class tests, assignments, project work), and work habits. Include any attendance problems:

What classroom/school/program interventions have been tried to date?

- Adaptations (please attach current plan to this referral)
- Individual Program Plan (please attach current Individual Program Plan to this referral)
- Reading Recovery (outcome status: referred on or successfully discontinued)
- Literacy Support Plan reading writing
- Specialist Services: Speech-Language Guidance Alternate Program
 Other _____
- Resource/Learning Centre Support (explain: length of time, main focus, etc.)

- Classroom Strategies (Please list) _____

- Outside Agencies (Specify) _____
- Other _____

Signature of Principal

Date

Signature of School Program Planning Team Chair

Date

**Original to Special Documents Envelope (SDE)
Copy to School Psychologist**

.....continued

MEDICAL AND DEVELOPMENTAL HISTORY

To be completed by parent/guardian:

Student: _____

Family Doctor: _____

1. Did you have difficulty during the pregnancy and/or birth of your child?

Yes No If yes, please provide relevant details.

2. Has your child had any serious illnesses or been hospitalized?

Yes No If yes, please provide relevant details.

3. Is your child on medication?

Yes No If yes, please provide relevant details.

4. At what age did your child

crawl _____ walk _____ say 1st word _____ speak sentences _____ toilet trained _____

5. Any unusual behaviours (ie: temper tantrums, repetitive movements, fears, etc.)

6. Has vision and hearing been assessed? When? Any problems?

7. Is there a family history of any learning problems?

Yes No If yes, please provide relevant details

_____ Signature of Parent	_____ Date
------------------------------	---------------

**Original to Special Documents Envelope (SDE)
Copy to School Psychologist**

.....continued

GENERAL INFORMATION

To be completed by individual teachers

Student: _____

Relationships with peers:

Describe:

Relationship(s) with teachers(s):

Describe:

Behavioral tendencies (socially isolated, active, restlessness):

Describe:

Additional Comments: _____

_____	_____	_____
Teacher Signature	Subject Area	Date

Original to Special Documents Envelope (SDE)
Copy to School Psychologist



REFERRAL TO SEVERE LEARNING DISABILITIES PROGRAM

This form must be completed and submitted along with required documentation to the SLD Committee through the Coordinator of Student Services by April 15th.

School: _____	Date: _____
Student (Legal) Name: _____	D.O.B. (yy/mm/dd): _____
Classroom Teacher: _____	Grade: _____
Parent/Guardian Name: _____	Contact No.: _____

Reason for Referral: _____

Psycho-educational Assessment Completed: _____ **Date:** _____

Area(s) of difficulty related to SLD (check all applicable):

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Language Arts | <input type="checkbox"/> Mathematics | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Memory & Organization Skills | <input type="checkbox"/> Self Esteem |

Student's strengths: _____

Interventions that have been tried: (e.g. Resource, Reading Recovery, Speech-Language, etc.)

Intervention	Date Implemented
_____	_____
_____	_____
_____	_____
_____	_____

Support documentation that must be included:

- a copy of the student's Adaptations and/or Individual Program Plan
- a copy of a recent hearing and vision test (if available)
- samples of student's work (including error analysis and test)
- anecdotal comments from classroom teachers

Completed By: _____ Date: _____

Principal: _____ Date: _____

TO BE COMPLETED BY SLD COMMITTEE Recommended for SLD services YES <input type="checkbox"/> NO <input type="checkbox"/> Provide Reason _____

Coordinator of Student Services: _____ Date: _____

Original to Special Documents Envelope (SDE) when process is completed

SPECIAL DOCUMENTS ENVELOPE (SDE)

Name : _____ Date of Birth : _____

School: _____

Envelope Number: _____ (If more than one envelope is required for the student, number the envelopes.)

This envelope is to be kept in the student's Cumulative Record Folder, in a secure location. **For complete information regarding the use of this envelope, refer to Policies and Procedures Handbook, under Special Documents Envelope.**

LIST OF POSSIBLE INSERTS: CONFIDENTIAL INFORMATION ONLY

1. Student referrals and formal assessment reports (from the Tri County School Board) including:
 - referral and consent forms
 - level B/C assessment reports and acknowledgement of results
 - observation reports
 - authorization to obtain or release records form
 - program planning meeting notes, conference reports regarding confidential information including diagnosis, third party involvement and sensitive information
2. Third party information: referrals and report with informed consent from agencies, institutions, physicians and APSEA.
3. Documents not received with informed consent but which, in the opinion of the principal, affect the education and well being of the student such as:
 - legal documents: custody, change of name, and/or restraining orders
 - documents in connection with and including identification and placement appeals
 - notification of suspensions
 - administration of medications form
4. Documents in connection with a Student Services Appeal
5. Any other documents clearly identified as "CONFIDENTIAL"

As documents are received and added to this envelope, the contents form on the reverse of this envelope is to be completed.



TRANSFER AND RECEIPT OF RECORDS
(Request for Transfer of Student Records)

Student Information

Student Name: _____

Date of Birth: _____ Provincial Student Number: _____
YY/MM/DD

I would like to request the following student records:

- Type of student record: Cumulative record folder
 Confidential record (Special Documents Envelope)

Student records to be transferred from:

School name: _____

School address: _____

Student records to be transferred to:

School name: _____

School address: _____

To the attention of: _____

Title: _____

Student records requested by:

Name (please print): _____

Title/relationship to student: _____

Signature:

Name of parent/guardian (please print): _____

Parent/guardian signature: _____

**TRANSFER AND RECEIPT OF RECORDS
(Acknowledgement of Received Records)**

This form must be completed in duplicate by the school sending the student record and must be verified by the school receiving the record. Each school retains one copy.

Student Information

Student Name: _____

Provincial Student Number: _____

Type of student record: Cumulative record folder
 Confidential record (Special Documents Envelope)

Student records transferred from:

School name: _____

School address: _____

School authorized signature: _____

Date records were transferred: _____

DD/MM/YYYY

Name of parent/guardian: _____

Student records transferred to:

School name: _____

School address: _____

School authorized signature: _____

Date records were transferred: _____

DD/MM/YYYY

Please acknowledge receipt by returning a signed copy of this form to the originating school.