Tri-County
Regional Centre for Education

IV

FORMS

FORM 1

Tri-County
Regional Centre for Education

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: ____________________________

Contact No.: ________________________

Parent/Guardian Name: ___________________________

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

Revised June 2008

Tri-County
Regional Centre for Education

ASSESSMENT REPORT - LEVEL B

School: ______________________ **Date:** ______________________

Student (Legal) Name: ______________________ **D.O.B. (yy/mm/dd):** ______________________

Classroom Teacher: ______________________ **Grade:** ______________________

Contact No.: ______________________

Parent/Guardian Name: ______________________

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

Revised June 2008

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 Centre for Education 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 Centre for Education staff

between:

TRI-COUNTY REGIONAL CENTRE FOR EDUCATION
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)

Tri-County
Regional Centre for Education

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:

ummary 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.)

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?

- ☐ Attendance
- ☐ Student Report
- ☐ Communication Log
- ☐ Teacher Report
- ☐ Academic Achievement
- ☐ Behaviour Tracking Forms
- ☐ Other (explain): ______________________________

Review Date (4-6 weeks following implementation)**:** ______________________________

Person(s) Responsible:

Crisis Management Plan (if applicable)

TRANSITION PLAN

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

Meeting Dates: ______________________________

Transition Team Members: (sending and receiving)

Sending Team Members

Receiving Team Members

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

- ☐ Tour Facility
- ☐ Transfer of Equipment
- ☐ Bussing/Conveyance
- ☐ Professional Staff On-Site Visit
- ☐ Orientation Day(s)
- ☐ Specialized Training
- ☐ Modification of Facilities
- ☐ Other: ______________________________

Tri-County
Regional Centre for Education

Long Term Transition Goal:

Annual Outcome:

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

Parent/Guardian Initial:

☐ I agree with the Behaviour Management Plan ☐ I disagree with the Behaviour Management Plan

Parent/Guardian Signature

Date

Date

Date

Date

Date

Original to Cumulative Record Folder
Copy to Signatories

Revised June 2008

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:** ______________________
	Contact No.: ______________________
Parent/Guardian Name: ______________________	

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 ____		
______________________________ Regional Executive Director of Education	Approved ☐	Not approved ☐

Forward to Regional Executive Director of Education
Signed Copy to Special Documents Envelope

Revised June 2008

FORM 7

FORM 5B

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

Attach to Form 5A

Revised June 2008

Tri-County Regional Centre for Education

FORM 6

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

Revised June 2008

Tri-County Regional Centre for Education

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:

Tri-County Regional Centre for Education

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.)

- ☐ Tour Facility
- ☐ Bussing/Conveyance
- ☐ Orientation Day(s)
- ☐ Modification of Facilities
- ☐ Transfer of Equipment
- ☐ Professional Staff On-Site Visit
- ☐ Specialized Training
- ☐ 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

FORM 7

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:

Signature	Date
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

Revised June 2008

FORM 8

Tri-County
Regional Centre for Education

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

Revised June 2008

FORM 9

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

Revised June 2008

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:

- ☐ Formal Psycho-educational Assessment*
- ☐ Behavioural Consultation/Assessment*
- ☐ Counselling (Group/Individual)*
- ☐ 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.
Name of Student

______________________ ______________________
Parent/Guardian Signature Date

Original to Special Documents Envelope (SDE)

…..continued

***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.

Tri-County
Regional Centre for Education

FORM 11

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

Revised June 2008

Tri-County
Regional Centre for Education

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:

- ☐ Psychologist
- ☐ Resource
- ☐ Reading Recovery
- ☐ IWK

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: ______________________

Tri-County Regional Centre for Education

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

Tri-County
Regional Centre for Education

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: ____

____

…..continued

Tri-County
Regional Centre for Education

3. **MEDICAL HISTORY**

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

Additional information (hearing, vision, physical disability):

____

____

____

____

____

Original to Special Documents Envelope (SDE)
Copy to SLP

Tri-County
Regional Centre for Education

FORM 12B

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

FORM 12C

Revised June 2008

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 ☐ Lack of progress ☐

Lack of Compliance ☐ Parental Request ☐

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

Tri-County
Regional Centre for Education

FORM 13

Revised June 2008

PARENT/GUARDIAN CONSENT FOR ADMINISTRATION OF MEDICATIONS/MEDICAL PROCEDURES

Preamble

It is the Tri-County Regional Centre for Education'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 Tri-County Regional Centre for Education 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 Tri-County Regional Centre for Education 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 Centre for Education to administer medication or treatment as described herein to my child named above. I release any staff member and the Tri-County Regional Tri-County Regional Centre for Education 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 Centre for Education 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

Tri-County
Regional Centre for Education

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

FORM 14

Revised June 2008

PHOTO

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: ____

…..continued

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 ***<u>must be</u>*** 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)

FORM 15

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

Revised June 2008

FORM 16

PROGRAM PLANNING NOTES

☐ School Program Planning Team or

☐ Individual Program Planning Team

☐ Other

Name of Student: ______________________ **Grade:** __________

Date of Meeting/Time: __________________ **School:** ________________

Person(s) Present: ______________________________________

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

Revised June 2008

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
- Regional Executive Director of Education 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

Tri-County Regional Centre for Education

FORM 18

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 Regional Executive Director of Education Date

☐ Approved ☐ Not approved Reason: ______________________________

Original to Principal
Copy to Human Resources

Revised June 2008

Tri-County
Regional Centre for Education

FORM 19

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 Regional Executive Director of Education
Date

Original to Principal
Copy to Human Resources

Revised June 2008

Tri-County
Regional Centre for Education

FORM 20

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.

Original to Special Documents Envelope (SDE)

Tri-County
Regional Centre for Education

FORM 21

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.

Tri-County
Regional Centre for Education

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

Tri-County
Regional Centre for Education

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

Tri-County
Regional Centre for Education

REFERRAL FOR SCHOOL PSYCHOLOGICAL SERVICES

School: ________________________________ **Date:** ____________________

Student (Legal) Name: ______________________ **D.O.B. (yy/mm/dd):** ____________

Classroom Teacher: ________________________ **Grade:** ___________________

Contact No.: ________________

Parent/Guardian Name: _____________________

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

Tri-County Regional Centre for Education

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

Tri-County Regional Centre for Education

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

Revised June 2008

Tri-County
Regional Centre for Education

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

Tri-County
Regional Centre for Education

FORM 24

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:** ____________________

Contact No.: ________________

Parent/Guardian Name: ______________________

Reason for Referral: ____

Psycho-educational Assessment Completed: _____ **Date:** ___________________ **Area(s) of difficulty related to SLD** (check all applicable):

- ☐ Language Arts
- ☐ Mathematics
- ☐ Writing
- ☐ Reading
- ☐ Memory & Organization Skills
- ☐ 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 ☐ NO ☐ Provide Reason ________________________

Coordinator of Student Services: ______________________ Date: ______________

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

Tri-County
Regional Centre for Education

FORM 25

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: <u>CONFIDENTIAL INFORMATION ONLY</u>

1. Student referrals and formal assessment reports (from the Tri County Tri-County Regional Centre for Education) 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.

Tri-County
Regional Centre for Education

FORM 26

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:____

Tri-County
Regional Centre for Education

FORM 27

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.