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:** _____

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

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

FORM 3

Tri-County
Regional Centre for Education

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)

Revised June 2008

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: _____ **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

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

Tri-County
Regional Centre for Education

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 _____

_____ Approved ☐ Not approved ☐
Regional Executive Director of Education

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

Revised June 2008

FORM 7

Tri-County
Regional Centre for Education

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

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

Tri-County
Regional Centre for Education

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

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

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 individualized achievement assessment. I understand that school staff may be consulted and will receive information regarding the results.

Name of Student

_____ _____

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

Tri-County
Regional Centre for Education

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

FORM 10

Tri-County
Regional Centre for Education

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 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).

Name of Student

_____ _____

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

FORM 12A

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
- ☐ Reading Recovery
- ☐ Resource
- ☐ 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: _____

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: _____

_____

…..continued

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

Revised June 2008

Tri-County
Regional Centre for Education

FORM 12C

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

Revised June 2008

Tri-County
Regional Centre for Education

FORM 13

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

FORM 13

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

Revised June 2008

Tri-County
Regional Centre for Education

PHOTO

FORM 14

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 ***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)

FORM 15

Tri-County
Regional Centre for Education

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

Tri-County
Regional Centre for Education

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

Tri-County
Regional Centre for Education

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

Tri-County
Regional Centre for Education

FORM 17

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.

Revised June 2008

Tri-County
Regional Centre for Education

FORM 22

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

FORM 23

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

Tri-County
Regional Centre for Education

FORM 23

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

Tri-County
Regional Centre for Education

FORM 23

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.