**K-12 PRE-EVALUATION PLANNING FORM**

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| * Initial Evaluation * Re-evaluation | Determination  Parent Referral (attach Parent Referral Form) |

Date: School:

Name of Person Making Request:

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Student Name: Birthdate: Age: Sex: Grade:

Parent/Guardian: Cell Phone:

Email Address:

Mailing Address:

**Medical History**

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| --- | --- |
| Date of hearing evaluation:  Results   * Pass * Fail | Date of vision evaluation:  Results  Pass  Fail |

Other significant medical history:

|  |  |  |
| --- | --- | --- |
| **Area** | **Test Name** | **Person Responsible** |
| **Academic**  “This area identifies a child’s strengths and weaknesses in subject areas including pre-academic skills, math, reading, and written language. We will conduct a review of information and may conduct an assessment in this area one-on-one with your child. Observations may be completed in school or classroom settings.” |  | * School Psych/ * Educational Diagnostician   Name: |
| **Intellectual**  “This area provides an indication of a child’s potential functioning in an educational environment. We will conduct a review of information and may conduct an assessment in this area one-on-one with your child.” |  | * School Psych   Name: |
| **Perceptual/Motor**  **“**This area assesses muscle strength, perceptual development, fine and/or gross motor skills, posture, gait, balance and coordination, and/or motor developmental levels. We will conduct a review of information and may conduct an assessment in this area one-on-one with your child.” |  | * OT * PT   Name (OT):  Name (PT): |
| **Social/Emotional**  “This area provides an indication of the student’s social and emotional development as it pertains to the educational environment. We will conduct a review of information and may conduct an assessment in this area one-one-one with your child. We may collect rating scales, conduct interviews and we may complete observations within the school.” |  | * School Psych/ * Educational Diagnostician * Behavior Consultant * Autism Specialist   Name(s): |
| **Speech/Language**  “This area identifies a child’s ability to communicate within his/her environment. Areas of evaluation might include articulation, receptive and/or expressive language, fluency and/or voice. We will conduct a review of information and may conduct an assessment in this area one-on-one with your child.” |  | * SLP   Name: |
| **Other**  **(These are suggestions, DO NOT COPY & PASTE in SRS)**  Vision Assessment  Hearing Assessment  Medical Status Update  On the Consent, list only the areas above that will be assessed. Do not list an item if it will not be assessed. | Statement created by Psych/Ed Diag.: | * School Psych/ * Educational Diagnostician * Behavior Consultant * Vision Specialist * DHH Teacher * Other   Name(s): |

**Required Attachment**

* Signed SRS Notice & Consent for Evaluation (to be completed with your chief evaluator)

**Signatures**

Building Administrator Date

Classroom Teacher or Case Manager Signature Date

Chief Evaluator Signature Date

(School Psych, Educational Diagnostician, SLP, etc.)

S.