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

|  |  |
| --- | --- |
| * [ ]  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**

|  |  |
| --- | --- |
| 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.