SD #48
Sea to Sky

SCHOOL DISTRICT NO. 48

♦ *Squamish* ♦ *Whistler* ♦ *Pemberton*

REQUEST FOR STUDENT SUPPORT SERVICES

Student's Name:_____ Last / First Date of Birth: _____ Year / Month / Day Sex: Male ☐ Female ☐	Teacher:_____ School:_____ Grade: _____ Date: _____

Child Resides With: _____ Phone: _____

Legal Guardian (if different): _____ Phone: _____

Email: _____

Reports should be mailed to: _____
(name)
_____
(address)
_____

District Student Support Services Requested (check those applicable)

_____ School Psychologist: (Behaviour) _____ (Ed.Psych.) _____ File Review _____

_____ Speech/Language Pathologist

_____ Hearing Resource Teacher

_____ Counselling (Elementary)

_____ Low Incidence Support Team
(School Psychologist signs for LIST)

_____ Occupational Therapy (School Psychologist signs for OT)

_____ Physiotherapist (School Psychologist signs for PT)

_____ Vision Impairment Service

_____ MIST (Multi Interdisciplinary Support Team Observation)
(School Psychologist Initial Here: _____)

**** All specialists indicated must be consulted prior to the referral and sign as outlined on page 5.***

Reason for Referral and questions you want to have answered.

What is the primary referral question the school would like addressed? (e.g., Does this student meet Ministry criteria as a special needs student?; Does the student demonstrate a learning disability?; What would be an effective intervention strategy?; Does the student demonstrate behaviour that is significantly different from their peers?

_____
_____
_____
_____
_____

EDUCATIONAL INFORMATION:

	Well Below Average	Below Average	Average	Above Average	Well Above Average
Reading Progress	☐	☐	☐	☐	☐
Writing Progress	☐	☐	☐	☐	☐
Oral Communication	☐	☐	☐	☐	☐
Math Progress	☐	☐	☐	☐	☐
Social Development	☐	☐	☐	☐	☐
Attitude	☐	☐	☐	☐	☐

Attendance: Poor ☐ Fair ☐ Good ☐ If Poor Record # of Days Missed this year _____

Most Recent Standardized Test Scores:
Date: _____ Date: _____ Date: _____
Test: _____ Test: _____ Test: _____

Subtests	S.S.	Subtests	S.S.

Previous Special Services Request: Yes ☐ No ☐

Schools Attended Previously: Yr: _____ Name: _____
_____ _____
_____ _____
_____ _____

STUDENT'S STRENGTHS

1. _____
2. _____
3. _____

STUDENT'S LIMITATIONS/AREAS OF CONCERN

1. _____
2. _____
3. _____

PREVIOUS & CURRENT INTERVENTIONS

Date:
(From _____ to _____) Intervention: _____ Person Responsible: _____
_____ _____
(From _____ to _____) Intervention: _____ Person Responsible: _____
_____ _____
(From _____ to _____) Intervention: _____ Person Responsible: _____
_____ _____
(From _____ to _____) Intervention: _____ Person Responsible: _____
_____ _____
(From _____ to _____) Intervention: _____ Person Responsible: _____
_____ _____

REMEMBER TO ATTACH ALL RELEVANT PREVIOUS L.A., MEDICAL, SPEECH-LANGUAGE, PSYCHOEDUCATIONAL &/OR COUNSELLING REPORTS TO THIS REFERRAL.

MEDICAL/PHYSICAL HISTORY: **This section to be completed by the student's parent/guardian prior to referral.**

VISION: When was your child's vision last checked? (Date) _____

By whom? _____

What were the results? _____

HEARING: When was your child's hearing last checked? (Date) _____

By whom? _____

What were the results? _____

GENERAL HEALTH:

Is your child presently in good health? _____

Has your child had any serious illnesses, accidents or operations? If yes, please Describe. _____

_____

Has your child a history of chronic colds, high fevers, ear infections? _____

Does your child have any allergies? _____ List them: _____

Asthma? _____ _____

Is your child presently on any medication? _____

If yes, please name the medication. _____

Is the medication taken: In school: _____ Only at home: _____

Medical diagnosis if any: _____

BIRTH HISTORY:

Length of pregnancy: _____ months

Child's weight at birth: _____ lbs. or _____ grams

Were there any concerns for your child's health at birth? Explain: _____

_____

Child is the _____ of _____ children.
(1^{st}, 2^{nd}, etc.) (Total)

PHYSICAL DEVELOPMENT:

Compared to other family members, your child's development appears:

(a) faster _____ (b) the same _____ (c) slower _____

REQUEST FOR STUDENT SUPPORT SERVICES

Was there ever any concern (by parents, other family members, doctors) with regard to your child's:

	Yes	No
feeding	☐	☐
fine motor skills (grasping objects with fingers, etc.)	☐	☐
gross motor skills (walking, running, etc.)	☐	☐
language development (age at which first used words, etc.)	☐	☐
articulation of words (speech)	☐	☐
memory/attention	☐	☐
hearing	☐	☐
impulsivity	☐	☐
vision	☐	☐
seizures	☐	☐
personal skills (toileting, etc.)	☐	☐
social skills (eg. a reluctance to play with others)	☐	☐
emotional stability (excessive crying, insecurity, anxiety, etc.)	☐	☐

If there were concerns for any of the above behaviors, please explain in more detail.

_____

_____

_____

_____

LANGUAGES SPOKEN AT HOME: _____

OTHER FACTORS:

Have significant changes or circumstances occurred at home which would be important to your child's adjustment?

_____

_____

_____

REQUEST FOR STUDENT SUPPORT SERVICES

PARENTS' COMMENTS: _____

_____

_____

_____

_____

ALL SIGNATURES BELOW MUST BE OBTAINED PRIOR TO FORWARDING THIS REFERRAL TO THE DISTRICT SPECIAL EDUCATION DEPARTMENT.

_____ _____
Signature of Teacher (or Secondary Counsellor) Date

_____ _____
Signature of L.A. or Resource Teacher Date

_____ _____
Signature of Principal Date

_____ _____
Signature of District Staff Representative Date

_____ _____
Signature of District Staff Representative Date

PARENTAL/GUARDIAN INFORMED CONSENT:

Before you sign

- Please make sure you understand the reason for the referral
- Please read the information in the completed referral
- Please add your own comments to the referral

By signing this form, I give my consent to the services requested

_____ _____
Signature of Parent/Guardian Relationship

_____
Date