

	<b>Student Intervention and Data Review (Elementary) SIDR Referral for Educational Concerns</b>	Contact Person:
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<b>STUDENT INFORMATION (1)</b>
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Student:	Parent/Guardian:
D.O.B.: <input type="checkbox"/> Male <input type="checkbox"/> Female	Address:
District:	Phone:
Student resides with parent: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, who does the student reside with?	
<b>Race and Ethnicity (required):</b>	Is student Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
If student is not Hispanic or Latino, one box must be checked from the following choices:	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White
Native Language of Child:	Native Language of Parent:
Kindergarten Teacher:	Grade 4 Teacher:
Grade 1 Teacher:	Grade 5 Teacher:
Grade 2 Teacher:	Other:
Grade 3 Teacher:	Other:
<input type="checkbox"/> Initial Meeting      Date:	<input type="checkbox"/> Follow-up Meeting      Date:
<input type="checkbox"/> Follow-up Meeting      Date:	<input type="checkbox"/> Follow-up Meeting      Date:
<input type="checkbox"/> Follow-up Meeting      Date:	<input type="checkbox"/> Follow-up Meeting      Date:
<input type="checkbox"/> Follow-up Meeting      Date:	<input type="checkbox"/> Follow-up Meeting      Date:

<b>MEDICAL INFORMATION (2)</b>
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VISION Screen Passed:	DATE	Grade	Screen Passed	DATE	Grade	Comments
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Glasses Prescribed:	<input type="checkbox"/> yes <input type="checkbox"/> no		Glasses Prescribed:	<input type="checkbox"/> yes <input type="checkbox"/> no		
Glasses Prescribed:	<input type="checkbox"/> yes <input type="checkbox"/> no		Glasses Prescribed:	<input type="checkbox"/> yes <input type="checkbox"/> no		
HEARING Screen Passed:	DATE	Grade	Screen Passed	DATE	Grade	Comments
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Tubes in Ears	<input type="checkbox"/> yes <input type="checkbox"/> no		Tubes in Ears	<input type="checkbox"/> yes <input type="checkbox"/> no		

**Describe Any Medical Concerns/Diagnosis:**

Date:	Concerns:
Current Medication:	
Date:	Concerns:
Current Medication:	
Date:	Concerns:
Current Medication:	
Date:	Concerns:
Current Medication:	
Date:	Concerns:
Current Medication:	

**MEETING LOG (3)**

Meeting Log: Date, Grade, School, District and Concern	Team Participants (Name, Title)	Next Steps To Address Concern
Concern:		
Concern:		
Concern:		
Concern:		
Concern:		
Concern:		
Concern:		
Concern:		

**STUDENT HISTORY (4) -- Attach attendance or behavioral reports as appropriate.**

**ATTENDANCE**

Dates Attended	Grade	Building/ District	Attendance		Report Card Comments
			Absent	Tardy	

**NOTES:**

**BEHAVIOR**

No. of Office Referrals	No. of ISS / RTC Referrals	No. of OSS Days	Behaviors Exhibited

**EDUCATIONAL INTERVENTIONS (6)**

**Preschool**

Choose One      Choose One      Choose One      Choose One      Choose One

**LEVEL 1 INTERVENTIONS**

Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
<input type="checkbox"/> Parents as Teachers	<input type="checkbox"/> Parents as Teachers	<input type="checkbox"/> Parents as Teachers	<input type="checkbox"/> Parents as Teachers	<input type="checkbox"/> Parents as Teachers	<input type="checkbox"/> Parents as Teachers
<input type="checkbox"/> Behavior Plan	<input type="checkbox"/> Behavior Plan	<input type="checkbox"/> Behavior Plan	<input type="checkbox"/> Behavior Plan	<input type="checkbox"/> Behavior Plan	<input type="checkbox"/> Behavior Plan
<input type="checkbox"/> Computerized Program:	<input type="checkbox"/> Computerized Program:	<input type="checkbox"/> Computerized Program:	<input type="checkbox"/> Computerized Program:	<input type="checkbox"/> Computerized Program:	<input type="checkbox"/> Computerized Program:
<input type="checkbox"/> Tutor	<input type="checkbox"/> Tutor	<input type="checkbox"/> Tutor	<input type="checkbox"/> Tutor	<input type="checkbox"/> Tutor	<input type="checkbox"/> Tutor
<input type="checkbox"/> Counseling	<input type="checkbox"/> Counseling	<input type="checkbox"/> Counseling	<input type="checkbox"/> Counseling	<input type="checkbox"/> Counseling	<input type="checkbox"/> Counseling
<input type="checkbox"/> After School Program	<input type="checkbox"/> After School Program	<input type="checkbox"/> After School Program	<input type="checkbox"/> After School Program	<input type="checkbox"/> After School Program	<input type="checkbox"/> After School Program
<input type="checkbox"/> Mentor Program	<input type="checkbox"/> Mentor Program	<input type="checkbox"/> Mentor Program	<input type="checkbox"/> Mentor Program	<input type="checkbox"/> Mentor Program	<input type="checkbox"/> Mentor Program
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

**LEVEL 2 INTERVENTIONS**

Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
<input type="checkbox"/> Letter/Sound ID	<input type="checkbox"/> Title 1 literacy groups	<input type="checkbox"/> Title 1 literacy groups	<input type="checkbox"/> Title 1 literacy groups	<input type="checkbox"/> Title 1 literacy groups	<input type="checkbox"/> Title 1 literacy groups
<input type="checkbox"/> Extra support from Instructional Assistant	<input type="checkbox"/> Extra support from Instructional Assistant	<input type="checkbox"/> Extra support from Instructional Assistant	<input type="checkbox"/> Extra support from Instructional Assistant	<input type="checkbox"/> Extra support from Instructional Assistant	<input type="checkbox"/> Extra support from Instructional Assistant
<input type="checkbox"/> Fine Motor	<input type="checkbox"/> Daily Motor group	<input type="checkbox"/> Daily Motor group	<input type="checkbox"/> Daily Motor group	<input type="checkbox"/> Daily Motor group	<input type="checkbox"/> Daily Motor group
<input type="checkbox"/> Observation	<input type="checkbox"/> Title 1 Math Support	<input type="checkbox"/> Title 1 Math Support	<input type="checkbox"/> Title 1 Math Support	<input type="checkbox"/> Title 1 Math Support	<input type="checkbox"/> Title 1 Math Support
<input type="checkbox"/> Oral Language	<input type="checkbox"/> Computerized Program:	<input type="checkbox"/> Computerized Program:	<input type="checkbox"/> Computerized Program:	<input type="checkbox"/> Computerized Program:	<input type="checkbox"/> Computerized Program:
<input type="checkbox"/> Bi-lingual Services	<input type="checkbox"/> Visual Processing Skills	<input type="checkbox"/> Visual Processing Skills	<input type="checkbox"/> Visual Processing Skills	<input type="checkbox"/> Visual Processing Skills	<input type="checkbox"/> Visual Processing Skills
<input type="checkbox"/> Daily Motor group	<input type="checkbox"/> After School Help	<input type="checkbox"/> After School Help	<input type="checkbox"/> After School Help	<input type="checkbox"/> After School Help	<input type="checkbox"/> After School Help
<input type="checkbox"/> Other:	<input type="checkbox"/> Bi-lingual Services	<input type="checkbox"/> Bi-lingual Services	<input type="checkbox"/> Bi-lingual Services	<input type="checkbox"/> Bi-lingual Services	<input type="checkbox"/> Bi-lingual Services
	<input type="checkbox"/> Reading Recovery				
	<input type="checkbox"/> Discontinued				
	<input type="checkbox"/> Not discontinued				
	<b>Coordination w/ Ancillary staff for classroom interventions:</b>				
	<input type="checkbox"/> Fine Motor	<input type="checkbox"/> Fine Motor	<input type="checkbox"/> Fine Motor	<input type="checkbox"/> Fine Motor	<input type="checkbox"/> Fine Motor
	<input type="checkbox"/> Oral Language	<input type="checkbox"/> Oral Language	<input type="checkbox"/> Oral Language	<input type="checkbox"/> Oral Language	<input type="checkbox"/> Oral Language
	<input type="checkbox"/> Observation	<input type="checkbox"/> Observation	<input type="checkbox"/> Observation	<input type="checkbox"/> Observation	<input type="checkbox"/> Observation
	<input type="checkbox"/> Behavior specialist	<input type="checkbox"/> Behavior specialist	<input type="checkbox"/> Behavior specialist	<input type="checkbox"/> Behavior specialist	<input type="checkbox"/> Behavior specialist
	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

LEVEL 3 INTERVENTIONS					
Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
<input type="checkbox"/> Diagnostic Testing to Plan Interventions Date:	<input type="checkbox"/> Diagnostic Testing to Plan Interventions Date:	<input type="checkbox"/> Diagnostic Testing to Plan Interventions Date:	<input type="checkbox"/> Diagnostic Testing to Plan Interventions Date:	<input type="checkbox"/> Diagnostic Testing to Plan Interventions Date:	<input type="checkbox"/> Diagnostic Testing to Plan Interventions Date:
<input type="checkbox"/> Speech Therapist <input type="checkbox"/> Occup. Therapy <input type="checkbox"/> Informal Testing Date:	<input type="checkbox"/> Speech Therapist <input type="checkbox"/> Occup. Therapy <input type="checkbox"/> Informal Testing Date:	<input type="checkbox"/> Speech Therapist <input type="checkbox"/> Occup. Therapy <input type="checkbox"/> Informal Testing Date:	<input type="checkbox"/> Speech Therapist <input type="checkbox"/> Occup. Therapy <input type="checkbox"/> Informal Testing Date:	<input type="checkbox"/> Speech Therapist <input type="checkbox"/> Occup. Therapy <input type="checkbox"/> Informal Testing Date:	<input type="checkbox"/> Speech Therapist <input type="checkbox"/> Occup. Therapy <input type="checkbox"/> Informal Testing Date:
<input type="checkbox"/> Cognitive Proc Screen Date:	<input type="checkbox"/> Cognitive Proc Screen Date:	<input type="checkbox"/> Cognitive Proc Screen Date:	<input type="checkbox"/> Cognitive Proc Screen Date:	<input type="checkbox"/> Cognitive Proc Screen Date:	<input type="checkbox"/> Cognitive Proc Screen Date:
<input type="checkbox"/> Play Therapy <input type="checkbox"/> Play Based Assess. Date:	<input type="checkbox"/> Play Therapy <input type="checkbox"/> Play Based Assess. Date:	<input type="checkbox"/> Play Therapy <input type="checkbox"/> Play Based Assess. Date:	<input type="checkbox"/> Play Therapy <input type="checkbox"/> Play Based Assess. Date:	<input type="checkbox"/> Play Therapy <input type="checkbox"/> Play Based Assess. Date:	<input type="checkbox"/> Play Therapy <input type="checkbox"/> Play Based Assess. Date:
<input type="checkbox"/> Observation Date: Observer:	<input type="checkbox"/> Observation Date: Observer:	<input type="checkbox"/> Observation Date: Observer:	<input type="checkbox"/> Observation Date: Observer:	<input type="checkbox"/> Observation Date: Observer:	<input type="checkbox"/> Observation Date: Observer:
<input type="checkbox"/> VIPA - Visual Processing Assess Date:	<input type="checkbox"/> VIPA - Visual Processing Assess Date:	<input type="checkbox"/> VIPA - Visual Processing Assess Date:	<input type="checkbox"/> VIPA - Visual Processing Assess Date:	<input type="checkbox"/> VIPA - Visual Processing Assess Date:	<input type="checkbox"/> VIPA - Visual Processing Assess Date:
<input type="checkbox"/> Formal Behavior Plan Date:	<input type="checkbox"/> Formal Behavior Plan Date:	<input type="checkbox"/> Formal Behavior Plan Date:	<input type="checkbox"/> Formal Behavior Plan Date:	<input type="checkbox"/> Formal Behavior Plan Date:	<input type="checkbox"/> Formal Behavior Plan Date:
<input type="checkbox"/> Diagnostic Behavior Assessment Date:	<input type="checkbox"/> Diagnostic Behavior Assessment Date:	<input type="checkbox"/> Diagnostic Behavior Assessment Date:	<input type="checkbox"/> Diagnostic Behavior Assessment Date:	<input type="checkbox"/> Diagnostic Behavior Assessment Date:	<input type="checkbox"/> Diagnostic Behavior Assessment Date:
<input type="checkbox"/> LIPS Program	<input type="checkbox"/> Resource Teacher Literacy (RTI) Begin: End:	<input type="checkbox"/> Resource Teacher Literacy (RTI) Begin: End:	<input type="checkbox"/> Resource Teacher Literacy (RTI) Begin: End:	<input type="checkbox"/> Rating Scale Date: <input type="checkbox"/> Other: Date:	<input type="checkbox"/> Rating Scale Date: <input type="checkbox"/> Other: Date:
<input type="checkbox"/> Earobics Program	<input type="checkbox"/> Earobics Program	<input type="checkbox"/> Earobics Program	<input type="checkbox"/> Earobics Program	<input type="checkbox"/> 504 Plan: Date:	<input type="checkbox"/> 504 Plan: Date:
<input type="checkbox"/> Rating Scale Date:	<input type="checkbox"/> Rating Scale Date:	<input type="checkbox"/> Rating Scale Date:	<input type="checkbox"/> Rating Scale Date:		
<input type="checkbox"/> Other: Date:	<input type="checkbox"/> LIPS Program <input type="checkbox"/> Earobics Program	<input type="checkbox"/> LIPS Program <input type="checkbox"/> Earobics Program	<input type="checkbox"/> Other: Date:		
<input type="checkbox"/> 504 Plan: Date:	<input type="checkbox"/> Other: Date: <input type="checkbox"/> 504 Plan: Date:	<input type="checkbox"/> Other: Date: <input type="checkbox"/> 504 Plan: Date:	<input type="checkbox"/> Other: Date:		

SPECIAL EDUCATION -- Programs and Services					
Services:	Services:	Services:	Services:	Services:	Services:
<input type="checkbox"/> Early Childhood	<input type="checkbox"/> Early Childhood	<input type="checkbox"/> Early Childhood	<input type="checkbox"/> Early Childhood	<input type="checkbox"/> Early Childhood	<input type="checkbox"/> Early Childhood
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Occup. Therapy	<input type="checkbox"/> Occup. Therapy	<input type="checkbox"/> Occup. Therapy	<input type="checkbox"/> Occup. Therapy	<input type="checkbox"/> Occup. Therapy	<input type="checkbox"/> Occup. Therapy
<input type="checkbox"/> Speech/Lang. Therapy Eligibility: choose	<input type="checkbox"/> Speech/Lang. Therapy Eligibility: choose	<input type="checkbox"/> Speech/Lang. Therapy Eligibility: choose	<input type="checkbox"/> Speech/Lang. Therapy Eligibility: choose	<input type="checkbox"/> Speech/Lang. Therapy Eligibility: choose	<input type="checkbox"/> Speech/Lang. Therapy Eligibility: choose
<input type="checkbox"/> School Psychologist	<input type="checkbox"/> School Psychologist	<input type="checkbox"/> School Psychologist	<input type="checkbox"/> School Psychologist	<input type="checkbox"/> School Psychologist	<input type="checkbox"/> School Psychologist
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
Programs:	Programs:	Programs:	Programs:	Programs:	Programs:

<input type="checkbox"/> Teacher Consultant	<input type="checkbox"/> Teacher Consultant	<input type="checkbox"/> Teacher Consultant	<input type="checkbox"/> Teacher Consultant	<input type="checkbox"/> Teacher Consultant	<input type="checkbox"/> Teacher Consultant
<input type="checkbox"/> Resource Room	<input type="checkbox"/> Resource Room	<input type="checkbox"/> Resource Room	<input type="checkbox"/> Resource Room	<input type="checkbox"/> Resource Room	<input type="checkbox"/> Resource Room
<input type="checkbox"/> Categorical Room	<input type="checkbox"/> Categorical Room	<input type="checkbox"/> Categorical Room	<input type="checkbox"/> Categorical Room	<input type="checkbox"/> Categorical Room	<input type="checkbox"/> Categorical Room

MEETING MINUTES FORM (7)

TEACHER REPORTS:

PARENT REPORTS:

OTHER:

**STUDENT INTERVENTION (8)**

**INTERVENTION PROCESS** – *Monitored intervention strategy(ies) must be developed and documented. Except in emergency cases, intervention(s) must be in place for a minimum of six (6) weeks.*

Area of concern:

Date:

Intervention	Person(s) Responsible	Results of Implementation

**STUDENT INTERVENTION**

**INTERVENTION PROCESS** – *Monitored intervention strategy(ies) must be developed and documented. Except in emergency cases, intervention(s) must be in place for a minimum of six (6) weeks.*

Area of concern:

Date:

Intervention	Person(s) Responsible	Results of Implementation



**STUDENT INTERVENTION**

**INTERVENTION PROCESS** – *Monitored intervention strategy(ies) must be developed and documented. Except in emergency cases, intervention(s) must be in place for a minimum of six (6) weeks.*

Area of concern:

Date:

Intervention	Person(s) Responsible	Results of Implementation

**STUDENT INTERVENTION**

**INTERVENTION PROCESS** – *Monitored intervention strategy(ies) must be developed and documented. Except in emergency cases, intervention(s) must be in place for a minimum of six (6) weeks.*

Area of concern:

Date:

Intervention	Person(s) Responsible	Results of Implementation

**ENGLISH LANGUAGE LEARNER (9)-- Assessments**

**English Language Proficiency Assessment (ELPA)**

Grade:	Overall Score:		* <b>Advanced Proficient</b> or <b>Proficient</b> needed to rule out factor impacting inadequate achievement
Grade:	Overall Score:		

**Peabody Picture Vocabulary Test (PPVT)**

Grade:	English Standard Score:	Spanish Standard Score:
Grade:	English Standard Score:	Spanish Standard Score:

**ACHIEVEMENT (10) -- Kindergarten Skills**

Date:						
Grade:						
<i>Criterion</i>	K Brigance:					

**BENCHMARK**

**DIBELS (At= W, Low = S)**

Letter Naming Fluency:						
Risk Indicators:	< 2 At Risk	< 15 At Risk	< 29 At Risk			
	> 8 Low Risk	> 27 Low Risk	> 40 Low Risk			
Initial Sound Fluency:						
Risk Indicators:	< 4 At Risk	< 10 At Risk	< 10 At Risk			
	> 8 Low Risk	> 25 Low Risk	> 25 Low Risk			

**MLPP**

Letter ID (54 Possible):						
Sound ID (26 Possible):						
Rhyme Choice (8 Possible):						
Rhyme Supply (8 Possible):						
Onset/Rime (8 Possible):						
Phoneme Blending (8 Possible):						
Phoneme Segmentation (8 Possible):						
Hearing Sounds (36 Possible):						
MLPP Oral Language Rubric (4)						

**NUMBERS**

Counts to:						
Identifies:						
One to One Correspondence:						
Counts by 5 to:						
Counts by 10 to:						

**Notes:**

**ACHIEVEMENT -- Benchmark Assessments**

Date:											
Grade:											
Running Record Level:											
% of MLPP Sight Words:											
Other Sight Words Score:											
Star Reading:											
DIBELS ORF (fluency):											
DIBELS Risk Indicator:											
STAR Math											
AR Reading:											
MLPP Writing Rubric: (4)											

**ACHIEVEMENT -- Curriculum Assessments**

**NUMBER OF CMS OUTCOMES MASTERED/TESTED**

Date:											
Grade:											
Language Arts:											
Math:											
Science:											
Social Studies:											

**GRADES:**

Language Arts:											
Math:											
Science:											
Social Studies:											
Spelling:											
Homework:											
Reading:											
Other:											

**ACHIEVEMENT -- State Tests**

**MEAP**

Grade	Reading				Writing				Math				Science				Social Studies			
3rd	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4th	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5th	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

**OTHER STATE TESTS**

Name of Test:	Grade:	Date:	Score:
Name of Test:	Grade:	Date:	Score:

**OTHER FACTORS THAT MAY AFFECT PERFORMANCE (11) -- Check each area with sufficient data.**

**CRITERIA:** Data on other factors that may affect performance on appropriate age / grade-level standards or activities.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Vision            | <input type="checkbox"/> Cognitive                            | <input type="checkbox"/> English as a Second Language |
| <input type="checkbox"/> Hearing           | <input type="checkbox"/> Social/Emotional                     | <input type="checkbox"/> Autism Spectrum Disorder     |
| <input type="checkbox"/> Health            | <input type="checkbox"/> Cultural                             | <input type="checkbox"/> Other:                       |
| <input type="checkbox"/> Motor Functioning | <input type="checkbox"/> Environmental, Economic Disadvantage | <input type="checkbox"/> Other:                       |

List date & existing information for any checked area(s).

List date & data needed for any unchecked area(s).

**DIAGNOSTIC ASSESSMENT RESULTS**

***SIDR TEAM SIGNATURES***

Meeting Date: \_\_\_\_\_  
Child Study Coordinator: \_\_\_\_\_  
Principal: \_\_\_\_\_  
Regular Education Teacher: \_\_\_\_\_  
Reading Specialist: \_\_\_\_\_  
Early Learning Support Consultant: \_\_\_\_\_  
Ancillary Staff: \_\_\_\_\_  
Other: \_\_\_\_\_

I understand the contents of this intervention plan and agree to its implementation.

Parent Signature: \_\_\_\_\_  
Parent Signature: \_\_\_\_\_  
RTI Teacher: \_\_\_\_\_  
Other: \_\_\_\_\_

***SIDR TEAM SIGNATURES***

Meeting Date: \_\_\_\_\_  
Child Study Coordinator: \_\_\_\_\_  
Principal: \_\_\_\_\_  
Regular Education Teacher: \_\_\_\_\_  
Reading Specialist: \_\_\_\_\_  
Early Learning Support Consultant: \_\_\_\_\_  
Ancillary Staff: \_\_\_\_\_  
Other: \_\_\_\_\_

I understand the contents of this intervention plan and agree to its implementation.

Parent Signature: \_\_\_\_\_  
Parent Signature: \_\_\_\_\_  
RTI Teacher: \_\_\_\_\_  
Other: \_\_\_\_\_

***SIDR TEAM SIGNATURES***

Meeting Date: \_\_\_\_\_  
Child Study Coordinator: \_\_\_\_\_  
Principal: \_\_\_\_\_  
Regular Education Teacher: \_\_\_\_\_  
Reading Specialist: \_\_\_\_\_  
Early Learning Support Consultant: \_\_\_\_\_  
Ancillary Staff: \_\_\_\_\_

I understand the contents of this intervention plan and agree to its implementation.

Parent Signature: \_\_\_\_\_  
Parent Signature: \_\_\_\_\_  
RTI Teacher: \_\_\_\_\_  
Other: \_\_\_\_\_