

# PEABODY CHARTER SCHOOL



-----STUDENT SUCCESS TEAM-----

## SST Process

When you have serious concerns about a student (academic achievement, behavior, home life, etc.), please follow these steps:

### STEP 1

- a. Meet with your grade level team to discuss, create and implement new strategies. Review and try new interventions.
- b. Hold a meeting with the parent(s) to discuss your concerns.
- c. Document both meetings so that you can complete the SST form as needed.

### STEP 2 Then if the situation doesn't improve:

- a. Schedule a Student Study Team meeting. (See the green SST binder on top of the mailboxes.)
- b. Request the parent's attendance at the SST, and ask the parent to complete the Parent Form, emphasizing the importance of data that only the parent can supply.
- c. Complete the data as requested on the SST form using the cumulative file, input from the student's other teachers, classroom assessments, and anecdotal information.

### STEP 3

- a. Once the form is completed, submit to Claire's box by the Monday before the SST.
- b. Invite any other teachers who have significant information about the student.

### STEP 4

- a. Remind parent of meeting.
- b. Attend meeting. Bring the cumulative folder, classroom assessments, and examples of the student's work PLUS examples of typical student work, if that will be helpful for comparison.



## Peabody Charter School 10 Steps to a Student Success Team Referral

Teacher \_\_\_\_\_ Student \_\_\_\_\_

The purpose of a Student Success Team meeting is to provide a time and place for teachers and parents to come together to discuss ways to further help students who may be struggling in some area. We try to always draw on the student's strengths. Please complete the attached form to document interventions that have already been tried.

**NOTE: RSP students and students with IEPs and 504s should not be SST'd... they already receive specific and appropriate interventions.**

The following items must be completed by you before the meeting:

- \_\_\_ 1) **Sign up** to reserve DATE and TIME of meeting. Complete REMINDER slip and place in Claire's box. (Claire will put this slip back in your box to remind you of the meeting)
- \_\_\_ 2) **Inform parent** of meeting – date \_\_\_\_\_ time \_\_\_\_\_  
(As the date of the meeting approaches, it is very helpful to remind families about the meeting)
- \_\_\_ 3) **Send home** Parent Information letter and Parent Questionnaire
- \_\_\_ 4) **Review** Cum and Health Card
- \_\_\_ 5) **Talk to** last year's teacher. Invite if you feel it would be helpful.
- \_\_\_ 6) **Complete Referral Form** – use felt pen – **remember** to complete the strengths and concerns section-- DO NOT complete "action plan" or "person responsible" sections (this will be done in the meeting!).
- \_\_\_ 7) **Duplicate referral form** to make an **overhead transparency**– See Katie for transparencies and help with the copying!!!
- \_\_\_ 8) **Notify any other teachers** that should be at the meeting (**For example:** if the student is struggling in reading, be sure the reading teacher can attend the meeting!).
- \_\_\_ 9) If appropriate notify speech and language teacher
- \_\_\_ 10) **Bring the following to the meeting:** cum  
transparency  
work samples  
portfolio  
intervention checklist  
any other relevant information

**If you have questions, contact Tina, Becca, Claire, Tiffany or Dana.**



## Peabody Charter School SST Report

Date of Meeting: \_\_\_\_\_ Student: \_\_\_\_\_ DOB: \_\_\_\_\_ SST1 SST2  
 Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ Previous SST referral: \_\_\_\_\_ Parent Present: YES NO

<b>Attendance (#)</b> _____ Regular _____ Tardies _____ Irregular	<b>Health</b> Vision _____ Hearing _____ Date _____ Tested _____	<b>Social Skills</b> Leader _____ Accepted by peers _____ Isolated _____	<b>Social Behavior</b> In class _____ Out of class _____	<b>Independent Skills</b> Works well _____ Incomplete work _____ Needs frequent help _____
----------------------------------------------------------------------------	------------------------------------------------------------------------------	--------------------------------------------------------------------------------------	----------------------------------------------------------------	--------------------------------------------------------------------------------------------------------

Current scores: **CELDT** \_\_\_\_\_ Reading fluency: \_\_\_\_\_ WPM Language Development  
**STAR/CST: ELA** \_\_\_\_\_ Reading Selection Tests: \_\_\_\_\_ Primary language \_\_\_\_\_  
**MATH** \_\_\_\_\_ Math Chapter test: \_\_\_\_\_ EO \_\_\_ LEP \_\_\_ FEP \_\_\_\_\_

Current Progress (Include strengths)	Areas of Concern	Interventions currently in place	Action Plan	Person responsible

Goal # 1 \_\_\_\_\_ Percent Achieved: \_\_\_\_\_ %  
 Goal # 2 \_\_\_\_\_ Percent Achieved: \_\_\_\_\_ %  
 Goal # 3 \_\_\_\_\_ Percent Achieved: \_\_\_\_\_ %

Follow Up Date: \_\_\_\_\_



## **CLASSROOM INTERVENTION CHECKLIST**

---

### **Modification of Materials, Assignments, and Instruction**

- Individualization of Instruction
- Informal Testing
- Different Learning Approaches (multi-sensory)
- Reduce difficulty of task
- Monitor amount of verbal instruction
- Allow more time for task completion
- Adjust amount of required work
- Break task into smaller steps
- Adjust grouping
- Prompting (e.g. proximity, eye contact, touching)
- Use of technology (computer, calculator)
- Use of Organizational Strategies (notebook, checklist)
- Teach study skills
- Peer Tutor
- Parent Tutor
- Instructional Assistant One-on-One Work
- Homework Center
- Teacher Tutoring (non-class time)
- Study Carrels
- Vary voice volume as needed
- Use eye contact
- Use hands on shoulder contact
- Teacher circulating around room
- List assignments and/or instructions on board
- Use visual aids in giving instructions
- Modify Student Work Setting – Seating

### **Behavior Management**

- Establish clear routine
- Clarify Rules
- Daily/Weekly Progress Reports
- Positive Reinforcement of Appropriate Response
- Behavior Plan
- Removal from class, specialist, or specialty

### **Additional Personnel/Conferencing**

- Teacher/Student Conference
- Learning Center Consultation
- Consider physical health problem or needs with specialist/Josie

PEABODY CHARTER SCHOOL

CONFIDENTIAL

HEALTH, DEVELOPMENTAL, AND SOCIAL HISTORY

As you know, your child's progress is being discussed by the Student Study Team here, of which you are a member. For this meeting we need to obtain information concerning his or her family situation, health, development, language, schooling, and behavior at home. Please assist us by providing the following information and returning this form to the school at your earliest convenience. Thank you for your cooperation and important input.

CHILD'S NAME \_\_\_\_\_ DATE FORM COMPLETED \_\_\_\_\_

AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ MALE/FEMALE \_\_\_\_\_ ETHNICITY \_\_\_\_\_

FAMILY SITUATION

Parents/Guardians:

Name \_\_\_\_\_ Name \_\_\_\_\_
Occupation \_\_\_\_\_ Occupation \_\_\_\_\_
Living with student? Yes / No Living with student? Yes / No
Involved in child's upbringing? Yes / No Involved in child's upbringing? Yes / No
Educational/learning difficulties? Yes / No Educational/learning difficulties? Yes / No
Last grade completed: \_\_\_\_\_ Last grade completed: \_\_\_\_\_
Health status: \_\_\_\_\_ Good \_\_\_\_\_ Poor Health status: \_\_\_\_\_ Good \_\_\_\_\_ Poor
Comments: \_\_\_\_\_ Comments: \_\_\_\_\_

Are biological parents divorced or separated? Yes / No
If yes, please indicate when divorce/separation occurred and child's reaction \_\_\_\_\_

When needing to set limits or give consequences to your child, what works best for you? \_\_\_\_\_

Do parents/guardians agree or disagree about parenting, discipline, school problems, expectation, etc.?

Please explain \_\_\_\_\_

Siblings: (Please include foster, half, or step siblings)

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Living at home? Yes / No
Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Living at home? Yes / No
Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Living at home? Yes / No
Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Living at home? Yes / No
Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Living at home? Yes / No

Others living with student: \_\_\_\_\_

Has your child experienced either of the following?

Death of a loved one: Yes / No When? \_\_\_\_\_ Who? \_\_\_\_\_
Child's reaction \_\_\_\_\_
Severe illness or disability in the family: Yes / No When? \_\_\_\_\_ Who? \_\_\_\_\_
Child's reaction \_\_\_\_\_

Describe any major family problems, stresses, or changes that may involve or relate to the child: \_\_\_\_\_

Indicate any diseases which "run in the family" \_\_\_\_\_

List any community agencies working with your family (Regional Center, Human Services, Mental Health, New Vistas, County Probation, etc.) \_\_\_\_\_

**CHILD'S HEALTH & DEVELOPMENT**

Were there any problems or anything unusual about the following? (If answer is "yes", please explain)

Mother's pregnancy with child: Yes / No

Child's birth: Yes / No

Child's early development and health as an infant: Yes / No

During the pregnancy, did the mother use any of the following? (Give amount and frequency)

Alcohol	Yes / No	Prescription Medications	Yes / No
Marijuana	Yes / No	Tobacco	Yes / No
Other Drugs (Cocaine, heroin, etc.)	Yes / No	Caffeine (Coffee, colas, etc.)	Yes / No

Was your child born: \_\_\_\_ Early \_\_\_\_ On time \_\_\_\_ Late Child's weight at birth \_\_\_\_\_

Please fill in the age at which your child could: \_\_\_\_ Sit alone \_\_\_\_ Crawl  
\_\_\_\_ Walk \_\_\_\_ Speak (words)  
\_\_\_\_ Dress self \_\_\_\_ Speak (sentences)  
\_\_\_\_ Ride two-wheeled bike

Did you have any concerns about your child's early speech development or motor skills (coloring, writing, bike riding, sports skills, etc.)? (Please describe) \_\_\_\_\_

Has the child experienced any of the following? (If answer is "yes", please explain)

Serious illnesses or injuries Yes / No

Many or especially prolonged ear infections Yes / No

Problems with hearing or vision Yes / No

Recent or current health problems (including allergies) Yes / No

Taking medications regularly Yes / No

Nutritional concerns or problems sleeping Yes / No

**LANGUAGE**

What language(s) are spoken at home? \_\_\_\_\_

What language do you think is your child's strongest? \_\_\_\_\_

Has your child ever received bilingual instruction in school? Yes / No

If yes, please describe: \_\_\_\_\_

## **SCHOOL HISTORY**

Schools student has attended: _____	Grades: _____
(Please include preschool) _____	Grades: _____
_____	Grades: _____
_____	Grades: _____
_____	Grades: _____
_____	Grades: _____
_____	Grades: _____
_____	Grades: _____

Does your child have a regular place and time to do homework? Yes / No

Who helps with the child's homework? \_\_\_\_\_

Does the child:	Have problems with other students?	Yes / No
	Have problems making friends at school?	Yes / No
	Have problems getting along with teachers?	Yes / No
	Tend to get sick in the morning before school?	Yes / No

What subjects is the child having difficulty with? \_\_\_\_\_

Has your child ever been provided with special classes or services? Yes / No

If yes, please describe: \_\_\_\_\_

What extracurricular activities is your child involved in? \_\_\_\_\_

Has your child ever missed a lot of school due to illness, injury, or truancy? Yes / No

If yes, please describe: \_\_\_\_\_

## **CURRENT FUNCTIONING**

Does your child have any unusual behaviors or habit? Yes / No

If yes, please describe: \_\_\_\_\_

Are there any problems at home with your child's behavior? Yes / No

If yes, please describe: \_\_\_\_\_

Most of the time your child is: \_\_\_happy\_\_\_ \_\_\_worried\_\_\_ \_\_\_sad\_\_\_ \_\_\_angry\_\_\_ \_\_\_other\_\_\_

If other, please describe: \_\_\_\_\_



# PEABODY CHARTER SCHOOL

## CONFIDENCIAL

### HISTORIAL DE SALUD, DESARROLLO Y SOCIAL

Como saben, su hijo/a está siendo evaluado/a por el personal escolar. Para que la evaluación esta completa, tenemos que obtener información referente a su situación familiar, salud, desarrollo, idioma, educación y conducta en casa. Por favor, ayúdenos proporcionando la información siguiente y entregando este formulario en la escuela lo antes posible. Gracias por su cooperación y por sus opiniones tan importantes.

NOMBRE DEL NIÑO/A \_\_\_\_\_ FECHA AL COMPLETAR EL FORMULARIO \_\_\_\_\_

EDAD \_\_\_\_\_ FECHA DE NACIMIENTO \_\_\_\_\_ VARON/HEMBRA \_\_\_\_\_ ETNIA \_\_\_\_\_

#### SITUACIÓN FAMILIAR

Padres[Tutores:

Nombre \_\_\_\_\_

Nombre: \_\_\_\_\_

Ocupación: \_\_\_\_\_

Ocupación: \_\_\_\_\_

¿Viven con el/la alumno/a? \_\_\_\_\_ Sí / No

¿Viven con el/la aiumno/a? \_\_\_\_\_ Sí / No

¿Participan en la educación? \_\_\_\_\_ Sí / No

¿Participan en la educación? \_\_\_\_\_ Sí / No

¿Dificultades educativas/de aprendizaje? \_\_\_\_\_ Sí / No

¿Dificultades educativas/de aprendlzaje? \_\_\_\_\_ Sí / No

Ultimo grado completado: \_\_\_\_\_

Ultimo grado completado: \_\_\_\_\_

Estado de salud: \_\_\_\_\_ Buena \_\_\_\_\_ Mala

Estado de salud: : \_\_\_\_\_ Buena \_\_\_\_\_ Mala

Comentarios: \_\_\_\_\_

Comentarios: \_\_\_\_\_

Los padres bioiógicos están divorciados o separados? \_\_\_\_\_ Sí / No

Si responden Sí, por favor indicar cuándo ocurrió el divorcio/la separación y la reacción del niño/a: \_\_\_\_\_

Cuando hay qua marcar limites o dar consecuencias a su hijo/a, ¿qué es lo qua funciona mejor? \_\_\_\_\_

¿Los padres/tutores están de acuerdo o en desacuerdo sobre educación, disciplina, problemas escolares, expectativas, etc.? Por favor, explicar \_\_\_\_\_

Hermanos/as: *(Por favor, incluir hermanos/as de acogida (foster), hermanastros/as o adoptivos)*

Nombre \_\_\_\_\_

Edad \_\_\_\_\_

Grado \_\_\_\_\_

¿Vive en casa? \_\_\_\_\_ Sí / No

Nombre \_\_\_\_\_

Edad \_\_\_\_\_

Grado \_\_\_\_\_

¿Vive en casa? \_\_\_\_\_ Sí / No

Nombre \_\_\_\_\_

Edad \_\_\_\_\_

Grado \_\_\_\_\_

¿Vive en casa? \_\_\_\_\_ Sí / No

Nombre \_\_\_\_\_

Edad \_\_\_\_\_

Grado \_\_\_\_\_

¿Vive en casa? \_\_\_\_\_ Sí / No

Nombre \_\_\_\_\_

Edad \_\_\_\_\_

Grado \_\_\_\_\_

¿Vive en casa? \_\_\_\_\_ Sí / No

Otros que viven con el/la alumno/a: \_\_\_\_\_

¿Su hijo/a ha experimentado algo de lo siguiente? \_\_\_\_\_

Muerte de algún ser querido: \_\_\_\_\_ Sí / No ¿Cuándo? \_\_\_\_\_ ¿Quién? \_\_\_\_\_

Reacción del niño/a: \_\_\_\_\_

¿Enfermedad seria? \_\_\_\_\_ Sí / No ¿Cuándo? \_\_\_\_\_ ¿Quién? \_\_\_\_\_

Incapacidad en la familia? Reacción del niño/a: \_\_\_\_\_

Describir cualquier problema,- tensión o cambio familiar serio que afecte o se relacione con el/la niño/a: \_\_\_\_\_

Indicar cualquier enfermedad que se repita en la familia \_\_\_\_\_

Indicar las agencias comunitarias que estann trabajando con su familia (Centro Regional, Servicios Humanos, Salud Mental, Nuevas Vistas, Libertad a Prueba del Condado, etc.) \_\_\_\_\_

## SALUD Y DESARROLL DEL NIÑO/A

¿Hubo muchos problemas o algo fuera de lo normal sobre lo siguiente? (Si responde Sí, por favor, explicar)

Embarazo de la madre:  Sí /  No

Nacimiento del niño/a:  Sí /  No

Desarrollo y salud en la primera infancia:  Sí /  No

Durante el embarazo, ¿la madre usó algo de lo siguiente? (Indicar cantidad y frecuencia)

Alcohol	<input type="checkbox"/> Sí / <input type="checkbox"/> No	Medicinas Recetades	<input type="checkbox"/> Sí / <input type="checkbox"/> No
Marijuana	<input type="checkbox"/> Sí / <input type="checkbox"/> No	Tabaco	<input type="checkbox"/> Sí / <input type="checkbox"/> No
Otras drogas (cocaína, heroína, etc.)	<input type="checkbox"/> Sí / <input type="checkbox"/> No	Cafeína (café, colas, etc.)	<input type="checkbox"/> Sí / <input type="checkbox"/> No

¿Su hijo/a nació?:  Pronto  A tiempo  Tarde      Peso al nacer: \_\_\_\_\_

Por favor, indicar la edad a la que empezó a hacer lo siguiente:

<input type="checkbox"/> Sentarse solo	<input type="checkbox"/> Gatear
<input type="checkbox"/> Caminar	<input type="checkbox"/> Hablar (palabras)
<input type="checkbox"/> Vestirse solo	<input type="checkbox"/> Hablar (frases)
<input type="checkbox"/> Montar en bicicleta con dos ruedas	

¿Hubo algo que le preocupara sobre los inicios del desarrollo del habla o de las habilidades motrices (pintar con colores, escribir, montar en bicicleta, habilidades deportivas, etc.?)

(Por favor, describir) \_\_\_\_\_

¿Ha experiementado el niño/a alguna de las condiciones siguientes? (Si responde Sí, por favor, explicar)

Enfermedades o lesiones serias  Sí /  No

Muchas infecciones de oldo especiaimente largas  Sí /  No

Problemas del ofdo o de la vista  Sí /  No

Problemas de salud recientes o repetidos (incluyendo alergias)  Sí /  No

Toma medicinas regularmente  Sí /  No

Problemas de nutrición o para dormir  Sí /  No

## LENGUAJE

¿Qué idioma(s) se habla(n) en casa? \_\_\_\_\_

¿Qué idioma cree que es el más fuerte en su hijo/a? \_\_\_\_\_

¿Su hijo/a ha recibido alguna vez enseñanza bilingüe en la escuela? Sí / No

Si contesta Sí, por favor, describir: \_\_\_\_\_

## HISTORIA ESCOLAR

Escuelas a las que ha asistido:	_____	Grados: _____
(por favor, incluir la preescolar)	_____	Grados: _____
	_____	Grados: _____
	_____	Grados: _____
	_____	Grados: _____
	_____	Grados: _____
	_____	Grados: _____
	_____	Grados: _____

¿Tiene su hijo/a un lugar y una hora regulares para hacer la tarea? Sí / No

¿Quien le ayuda a hacer la tarea? \_\_\_\_\_

¿Tiene el/la niño/a algo de lo siguiente?

¿Problemas con otros alumnos?	Sí / No
¿Problemas para hacer amigos en la escuela?	Sí / No
¿Problemas para fievarse bien con los maestros?	Sí / No
¿Tendencia a ponerse enfermo antes de ir a la escuela?	Sí / No

¿Con qué materias está su niño/a teniendo dificultades? \_\_\_\_\_

¿Alguna vez su niño/a ha recibido clases o servicios especiales? Sí / No

Si contesta Sí, por favor, describir: \_\_\_\_\_

¿En qué actividades extraescolares participa su hijo/a? \_\_\_\_\_

¿Su hijo/a ha faltado mucho a la escuela debido a enfermedad, lesiones o ausencias injustificadas? Sí / No

Si contesta Sí, por favor, describir: \_\_\_\_\_

## FUNCIONAMIENTO ACTUAL

¿Su hijo/a tiene costumbres o hábitos poco corrientes? Sí / No

Si contesta Sí, por favor, describir: \_\_\_\_\_

¿Hay algo de problema con la conducta de su hijo/a en casa? Sí / No

Si contesta Sí, por favor, describir: \_\_\_\_\_

La mayor parte del tiempo su niño/a está:

\_\_\_ feliz    \_\_\_ preocupado/a    \_\_\_ triste    \_\_\_ enojado/a    \_\_\_ otro

Si contesta "otro", por favor, describir: \_\_\_\_\_

¿ Actualmente hay algo que le preocupa en la salud de su hijo/a? \_\_\_\_\_

\_\_\_\_\_

Por favor, indique los puntas fuertes, talentos y atributos positivos de su hijo/a: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Gracias por tomarse el tiempo necesario para responder estas preguntas. Si hay algo más que desee compartir con nosotros que no se haya preguntado en este cuestionario pero que considera importante en el rendimiento académico de su hijo/a, por favor, incluya sus comentarios en el espacio de abajo: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_