# JOHNSTON PUBLIC SCHOOLS

## *Special Services*

STUDENT_____ D.O.B. _____/_____/_____

SCHOOL _____ GRADE _____ TEACHER/COUNSELOR _____

PARENT/GUARDIAN _____ ADDRESS _____

TELEPHONE: (h) _____ (w) _____ (c) _____

The *Current Concerns Statement* is completed at the Evaluation Team meeting and forwarded as part of the team process to the appropriate evaluator.

Currently receiving special education services: ☐ Yes ☐ No

If yes - Primary Disability: _____

Current Service(s): _____ _____

| CURRENT EVALUATIONS | DATE | COMMENTS |
|---|---|---|
| Psychological | | (include personality testing) |
| Educational | | |
| Social | | |
| Medical: | | |
| Other: | | |
| Other agency evaluations: | | |

**Areas of Concern: (Check all areas that apply)**

**Memory**
___rate of learning
___recall of information

**Reading**
___phonics/word decoding
___comprehension
___spelling

**Fine/Gross Motor Control**
___pencil grasp
___manipulation of objects
___gait
___handwriting
___slow motor output

**Speech/Language**
___written language
___verbal expression
___auditory/listening comprehension
___stutters
___unusual or monotone voice quality

**Math**
___learning math facts
___basic operations (e.g., addition, subtraction)
___word problems

**Attention/Concentration**
___initiating tasks
___sustaining attention
___completing tasks
___organization
___activity level

**Spatial Orientation**
___aligning numbers in columns
___using rulers/graphs
___navigating to classes
___keeping writing on lines of paper
___drawing/copying designs

**Other**
___right/left confusion
___repetitive behavior (e.g., scratching, rubbing)
___perseveration
___periods of "spacing out" where child does not
___respond to verbal questions or requests

**Behavior/Emotions**
___oppositional/noncompliant
___destructive
___problems interpreting social cues
___aggressive
___easily frustrated
___sadness/depression
___problems maintaining friendships
___anxiety

# JOHNSTON PUBLIC SCHOOLS

***Special Services***

**NAME**: **D.O.B.**:

If this student is currently receiving special education services briefly describe:

Attach a copy of the service page of the IEP

Other support services in the school (e.g. Literacy, guidance, etc.)

Please list any *pertinent medical history* (e.g., injuries, operations, medical conditions such as diabetes, seizures, etc.)

Current medications (if any):

Please list interventions that have been attempted:

What questions would you like answered/addressed by this evaluation (attach additional pages as needed)?

Additional information:

_____ _____/_____/_____

CHAIR DATE