

## Referral Binder Contents

*All information listed below must be most current.*

<b>FORM</b>	<b>DATE</b>	<b>COMPLETE</b>
Referral for Special Education Services Form		<input type="checkbox"/>
Health- Hearing and Vision Screening Report from Nurse	Initial Screening: Recheck Date:	<input type="checkbox"/>
Information from Teachers		<input type="checkbox"/>
Teacher Observation Checklist for Speech (If Needed)		<input type="checkbox"/>
Copy of Home Language Survey		<input type="checkbox"/>
Copy of most recent LPAC data (applicable to all who are identified LEP)		<input type="checkbox"/>
Information from Parents		<input type="checkbox"/>
Documentation of dates/times of parent contacts		<input type="checkbox"/>
Report Cards (Current and previous years)		<input type="checkbox"/>
Copy of previous STAAR Scores (3 yrs where applicable)		<input type="checkbox"/>
Documentation of current attendance (include tardies and leaving early)		<input type="checkbox"/>
Copy of Behavioral Referrals		<input type="checkbox"/>
Work Samples Attached (writing, math problem solving, reading responses, etc.)		<input type="checkbox"/>
Parent Notice and Consent for Evaluation		<input type="checkbox"/>
Parent Receipt of Safeguards		<input type="checkbox"/>
Other information collected		<input type="checkbox"/>

Bandera ISD

Special Education Referral Parent Meeting Checklist and Notes

Student Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent Name: \_\_\_\_\_ Date of Meeting \_\_\_\_\_

School Representative Name: \_\_\_\_\_

Check when the following items are completed

- Notice of Full and Individual Evaluation (FIE) completed and copy given to parent.
- Consent for Full and Individual Evaluation completed and signed by parent.
- Parent receives Guide to the Admission, Review, and Dismissal Process and parent signs receipt.
- Parent completes "Information from Parents" forms (6 pages) and signs.
- Parent completes and signs "Home Language Survey".
- Discuss and explain Special Education Evaluation timelines and process as outlined on timeline chart.
- Parent informed that referrals are done in the order they are received.
- Parent informed of the diagnostician/LSSP's schedules-their responsibilities for more than one campus.
- Parent provided with Special Education Office and Diagnostician or LSSP assigned to campus contact information.
- Address any other parent concerns.

Meeting Notes:

---

---

---

---

---

---

---

---

---

---

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please include this completed document at the front of the referral packet.**

Date Initiated by  
General Education:

Date Received By  
Special Education:

Parental Consent Date:

**Bandera Independent School District  
Special Education Department  
Referral for Special Education Services**

Legal name of Student (Last name first)

Sex

Date of Birth

Age

Social Security Number

Grade

School District/ Campus

Name of Parent(s) or Guardian

Address

City

Zip

Home Telephone

Work Telephone

Student is receiving: \_\_\_\_\_ Bilingual/ESL \_\_\_\_\_ Title I \_\_\_\_\_ 504 monitoring \_\_\_\_\_ Tier II Reading  
Instruction \_\_\_\_\_ tutoring

**REASON FOR REFERRAL: (Area of concern)**

Parental Contact made by: \_\_\_\_\_ Conference \_\_\_\_\_ Telephone Call \_\_\_\_\_ Home Visit \_\_\_\_\_ other

Signature of person making parental contact concerning referral

Position

**STEPS FOR REFERRAL:**

- 1) Attach the Early Intervention Packet CFR 300.125 (a)(2)
- 2) Give parent(s) a copy of the EXPLANATION OF PROCEDURAL SAFEGUARDS and have the parent sign the Initial Receipt for Explanation of Procedural Safeguards Log CFR 300.504 (a)(2)
- 3) Ask parent (s) to fill out the Parent Information Data CFR 300.532 (b)
- 4) Fill out the two copies of the Notice of Full Individual Assessment. (parent copy/school copy) CFR 300.503 (c)(1)(i)(ii)
  - a) Date given to parent
  - b) Student data
  - c) Reason for referral
  - d) Options considered
  - e) Why these options were rejected
  - f) Date and to whom procedural safeguards were given
  - g) Name of contact person and their telephone No.
  - h) Signature of Interpreter, if used
- 5) Have parent check the appropriate items and sign the Consent for Full Individual Assessment CFR 300.503 (c)(1)(i)(ii)
- 6) An FIE will be completed. At the first ARD if the ARDC feels this student's difficulties may be related to emotional problems, the ARDC will request a screening and possible psychological assessment. Parent will sign consent for Psychological Evaluation at this time.

**ADMINISTRATIVE SIGNATURES:**

DATE

PRINCIPAL SIGNATURE

DATE

DIRECTOR OF SPECIAL EDUCATION

Bandera ISD  
Health Information

Date Received: \_\_\_\_\_

NAME \_\_\_\_\_

CFR 300.533 (c)

VISION

Machine Serial #: \_\_\_\_\_

Date of most recent screening: \_\_\_\_\_ Type of Vision Screening: \_\_\_\_\_

Name of person conducting the screening: \_\_\_\_\_ Position \_\_\_\_\_

Results: Right: \_\_\_\_\_ within normal limits?  Yes  No  
Left: \_\_\_\_\_ within normal limits?  Yes  No  
Corrective lenses?  Yes  No

HEARING

Machine Serial #: \_\_\_\_\_

Date of most recent screening: \_\_\_\_\_ Type of Hearing Screening: \_\_\_\_\_

Name of person conducting the screening: \_\_\_\_\_ Position \_\_\_\_\_

Results: Right: Threshold within normal limits?  Yes  No 

-	500
-	1K

-	2K
-	4K

  
Left: Threshold within normal limits?  Yes  No 

-	500
-	1K

-	2K
-	4K

Yes  No As a result of the vision/hearing screening, is there any indication of a need for further assessment or adjustment? If yes, please explain:

Yes  No Has any followup been recommended? If Yes, explain:

HEALTH

Yes  No Does the student exhibit any signs of health or medical problems? If Yes, cite observations:

Yes  No Is there a need for further assessment or referral of a medical problem? If Yes, explain:

Yes  No Is the student receiving any medication at school? If Yes, specify:

Yes  No Does this student require adaptive equipment or facility adaption? If Yes, specify:

\_\_\_\_\_  
Signature of Nurse

\_\_\_\_\_  
Date



**Bandera ISD**

**Information from Teachers**

Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Campus: \_\_\_\_\_

Rate the Student's Behavior in Each of the Following Areas: (Note: Rate in relation to other students at the SAME GRADE LEVEL.)

E. Academic Characteristics	Poor	Below Average	Average	Above Average	Superior	Not Observed
1. Read aloud material. (estimated grade level: _____ )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Comprehends material read. (estimated grade level: _____ )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Performs math computations at expected proficiency. (estimated grade level: _____ )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Performs math reasoning skills at expected proficiency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Spells material adequately. (estimated grade level: _____ )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Writes legibly. (estimated grade level: _____ )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Retains instruction from week to week.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Completes tasks on time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Organizes and relates ideas and factual information in written form.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Student services and special programs provided or considered in response to student's problem(s):

	How Long?	Currently?	Results
<input type="checkbox"/> Counseling		<input type="checkbox"/>	_____
<input type="checkbox"/> School health services		<input type="checkbox"/>	_____
<input type="checkbox"/> Special education		<input type="checkbox"/>	_____
<input type="checkbox"/> Speech therapy		<input type="checkbox"/>	_____
<input type="checkbox"/> Title I/compensatory education (Must be provided or considered for students before referral is completed.)		<input type="checkbox"/>	_____
<input type="checkbox"/> Bilingual program		<input type="checkbox"/>	_____
<input type="checkbox"/> Local remedial program (specify, e.g., PBS)		<input type="checkbox"/>	_____
<input type="checkbox"/> Other: _____		<input type="checkbox"/>	_____

Instructional modifications attempted in response to the student's problem(s) include:

	How Long?	Currently?	Results
<input type="checkbox"/> Individual tutoring		<input type="checkbox"/>	_____
<input type="checkbox"/> Ability grouping		<input type="checkbox"/>	_____
<input type="checkbox"/> Alternate materials		<input type="checkbox"/>	_____
<input type="checkbox"/> Change seat		<input type="checkbox"/>	_____
<input type="checkbox"/> Change class/teacher		<input type="checkbox"/>	_____
<input type="checkbox"/> Behavior management		<input type="checkbox"/>	_____
<input type="checkbox"/> Grading on basis of individual growth		<input type="checkbox"/>	_____
<input type="checkbox"/> Oral tests		<input type="checkbox"/>	_____
<input type="checkbox"/> Peer tutoring		<input type="checkbox"/>	_____
<input type="checkbox"/> Modified or shortened assignments		<input type="checkbox"/>	_____
<input type="checkbox"/> Extra time for completion of work		<input type="checkbox"/>	_____
<input type="checkbox"/> Taping of materials		<input type="checkbox"/>	_____
<input type="checkbox"/> Other 1: _____		<input type="checkbox"/>	_____
<input type="checkbox"/> Other 2: _____		<input type="checkbox"/>	_____

- Yes    No   Does this student exhibit any behaviors in the classroom which might indicate vision or hearing problems?
- Yes    No   Does this student exhibit any signs of a health or medical problem in the classroom? If yes, cite specific observations:

\_\_\_\_\_  
Signature of Teacher

\_\_\_\_\_  
Subject of Teacher

\_\_\_\_\_  
Date

Bandera ISD

Teachers Observation Checklist for Speech

Please check the following items you feel best describe the student's communication difficulties.

Articulation	Voice	Fluency	Oral Language	Hearing
<input type="checkbox"/> No concern noted <input type="checkbox"/> Omits sounds <input type="checkbox"/> Baby talk <input type="checkbox"/> Substitutes sounds ("w" for "r") <input type="checkbox"/> Sloppy speech <input type="checkbox"/> Speaks very little <input type="checkbox"/> Unintelligible speech  Notes:	<input type="checkbox"/> No concern noted <input type="checkbox"/> Monotonous <input type="checkbox"/> Harsh <input type="checkbox"/> Too high pitched <input type="checkbox"/> Too low pitched <input type="checkbox"/> Hoarse and husky <input type="checkbox"/> Too loud <input type="checkbox"/> Too weak <input type="checkbox"/> Nasal quality poor  Notes:	<input type="checkbox"/> No concern noted <input type="checkbox"/> Repeats sounds, syllables, and words <input type="checkbox"/> Blocks (can't get words out easily) <input type="checkbox"/> Irregular breathing patterns <input type="checkbox"/> Speaks too slowly <input type="checkbox"/> Speaks too fast	<input type="checkbox"/> No concern noted <input type="checkbox"/> Non-verbal <input type="checkbox"/> Grammatical problems-inability to use parts of speech appropriately <input type="checkbox"/> Syntactical problems-individual speaks in single words, brief pauses, and/or disarranged word order <input type="checkbox"/> Vocabulary-limited number of words or number of meanings of each word <input type="checkbox"/> ESL: Problem associated with English as a second language <input type="checkbox"/> Student is receiving other Special Education services  Notes:	<input type="checkbox"/> No concern noted <input type="checkbox"/> Complains of earache <input type="checkbox"/> Listless and weary expression <input type="checkbox"/> Frequent request for repetition <input type="checkbox"/> Mispronunciation of words <input type="checkbox"/> Turns one ear towards the speaker <input type="checkbox"/> Inattention: voice or speech peculiarities <input type="checkbox"/> Failure to respond when questioned <input type="checkbox"/> Closely watches face of speaker: appears to be lip-reading  Notes:

Signature of Regular Education Teacher: \_\_\_\_\_

Date: \_\_\_\_\_

**HOME LANGUAGE SURVEY**  
(Please copy original from PRC when available)

STUDENT'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_

1. What language is spoken in your home most of the time?

\_\_\_\_\_

2. What language does your child (do you) speak most of the time?

\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PARENT OF GUARDIAN

\_\_\_\_\_  
DATE

.....  
NOMBRE DEL ESTUDIANTE: \_\_\_\_\_ GRADO: \_\_\_\_\_

1. ¿Qué idioma se habla en su casa la mayoría del tiempo?

\_\_\_\_\_

2. ¿Qué idioma habla su hijo (¿usted hablan?) la mayoría del tiempo?

\_\_\_\_\_

\_\_\_\_\_  
FIRMA DEL PADRE OR TUTOR

\_\_\_\_\_  
FECHA



# RESULTS OF LANGUAGE DOMINANCE TESTING

Non applicable, Home Language Survey noted all English

Students Name: \_\_\_\_\_ DOB \_\_\_\_\_ Grade: \_\_\_\_\_

Test Used: \_\_\_\_\_ Date Given: \_\_\_\_\_

Results: English Level	1	2	3	4	5	Examiner: _____
Spanish Level	1	2	3	4	5	Examiner: _____

If the student scores a level 4 (near fluent) or 5 (fluent) on the English version, the Spanish version does not have to be given. However, if the student scores a level 3 or below, then the Spanish version must be administered.

Discussion: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Student is receiving ESL services                       Student is receiving Bilingual services  
 Student is English deficient but is not receiving ESL or Bilingual services

The LPAC representative recommended to attend the Campus Support Team Meeting and/or ARD Committee Meeting is: \_\_\_\_\_

Signature of ESL Teacher Collecting Data: \_\_\_\_\_

Date Completed: \_\_\_\_\_

## Information from Parents

NAME OF STUDENT: \_\_\_\_\_ SCHOOL: \_\_\_\_\_  
 HOME ADDRESS (street & city): \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_  
 GRADE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

PARENT/GUARDIAN #1 NAME: \_\_\_\_\_  
 RELATIONSHIP: \_\_\_\_\_ CELL NUMBER: \_\_\_\_\_  
 WORK NUMBER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

PARENT/GUARDIAN #2 NAME: \_\_\_\_\_  
 RELATIONSHIP: \_\_\_\_\_ CELL NUMBER: \_\_\_\_\_  
 WORK NUMBER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

**GENERAL INFORMATION:** (If additional space is needed, please use the back of this page)

The following information was obtained from: \_\_\_\_\_

Parent #1 Occupation: \_\_\_\_\_

Parent #2 Occupation: \_\_\_\_\_

\_\_\_\_ YES \_\_\_\_ NO Do both parents live in student's home? If not, with whom does student live?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Parent's education level:

Parent #1: \_\_\_\_\_ Parent #2: \_\_\_\_\_

*If primary caregivers work outside the home, please answer the following information:*

Who cares for this child when caregivers are gone? \_\_\_\_\_

How many hours per day is this child in a child-care setting? \_\_\_\_\_

How many different people care for this child? \_\_\_\_\_

**OTHER CHILDREN IN THE HOME:**

NAME	AGE	RELATIONSHIP

Do any of these children have learning problems? If yes, please explain:

\_\_\_\_\_

**OTHER ADULTS IN THE HOME:**

NAME	AGE	RELATIONSHIP

\_\_\_ YES \_\_\_ NO Have any other family members had learning problems? If yes, please explain:

The primary language spoken at home is: \_\_\_\_\_

How long has the student lived in the United States? \_\_\_\_\_

What time does the student go to bed at night? \_\_\_\_\_

Does your child eat breakfast? \_\_\_ YES \_\_\_ NO

**HEALTH HISTORY:**

\_\_\_ YES \_\_\_ NO Were there any complications with this child during pregnancy? *If YES, please check any of the following complications that occurred during pregnancy.*

Difficulty with conception	Toxemia	Abnormal weight gain	Measles German Measles
Excessive vomiting	Excessive swelling	Bleeding	Anemia
High Blood Pressure	Emotional Problems	Flu	Other
Maternal Injury: Describe: _____			
Hospitalization during pregnancy: _____			
X-Rays during pregnancy: What Month? _____			
Medications used during pregnancy: List _____			
Alcohol used during pregnancy: Frequency: _____			
Cigarettes used during pregnancy:		Frequency: _____	
Other drugs used during pregnancy: _____			
TYPE _____			
FREQUENCY _____			
PRESCRIPTION <input type="checkbox"/> Yes <input type="checkbox"/> No			

**INFORMATION SURROUNDING BIRTH:**

At this child's birth, what was the mother's age? \_\_\_\_\_ Father's age? \_\_\_\_\_

Was this child born in a hospital? \_\_\_ YES \_\_\_ NO If NO, where? \_\_\_\_\_

Length of pregnancy? \_\_\_\_\_ Weeks Birth Weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

Length of labor? \_\_\_\_\_ Hours Apgar score if known: \_\_\_\_\_

Child's condition at birth: \_\_\_\_\_

Mother's condition at birth: \_\_\_\_\_

Please check any of the following complications that occurred at birth:

Forceps used       Breech birth    Induced labor       Caesarian delivery

Other complication: Describe \_\_\_\_\_

Incubator used: How long? \_\_\_\_\_

Jaundiced: Biliruben lights?  YES  NO    If YES, how long? \_\_\_\_\_

Breathing problems right after birth? Describe: \_\_\_\_\_

Supplemental oxygen?  YES  NO    If YES, how long? \_\_\_\_\_

Was anesthesia used during delivery?  YES     NO    If YES, what kind? \_\_\_\_\_

Length of stay in hospital? Mother \_\_\_\_\_ Child \_\_\_\_\_

**Growth and Development:**

At what age (in months), was your child able to do the following?

SKILL	AGE IN MONTHS	SKILL	AGE IN MONTHS
Turn over		Walk down stairs	
Sit alone		Show interest in/attention to sound	
Crawl		Understand first words	
Stand alone		Speak first words	
Walk alone		Speak in sentences	
Walk up stairs			

When was this child toilet trained? \_\_\_\_\_

Trained during day at Age: \_\_\_\_\_

Trained during night: Age: \_\_\_\_\_

Does your child have or has he/she had any of the following:

	YES	NO	BEGAN AT AGE:	STOPPED AT AGE:	CONTINUES TO HAVE:
Frequent fevers					
Frequent earaches					
Frequent vomiting					
Frequent headaches					
Thumb sucking					
Nightmares					
Sleepwalking					
Head banging					
Rocking of body					
Teeth grinding					
Bed-wetting/Bed-soiling					

Biting fingernails					
Temper tantrums					
Run away from home					
Lost consciousness					
Convulsions					
Unclear speech					
Walking difficulty					
Difficulty learning to ride bike					
Difficulty learning to skip					

**CURRENT HEALTH INFORMATION:**

Doctor's reports, letters, and diagnoses can be very helpful to the RESULTS committee. Please attach those medical records so that the Committee can have a more complete picture of your child. If you would prefer, you may give THE DISTRICT written consent to seek those records from your doctor directly.

Please indicate whether you would like THE DISTRICT to contact your doctor directly:  YES  NO

*Consent for Release of Confidential Information will be provided to you for your signature.*

YES  NO Is your child under the care of a physician for a medical problem? If yes, please explain:

YES  NO Does your child appear to have any other physical health problems, including allergies?

YES  NO Is your child now taking any medications? If YES, please list: \_\_\_\_\_

YES  NO Do you know of any side effects the medication may have? If yes, please explain:

YES  NO Has your child ever taken medication for a long period of time? If yes, please explain:

YES  NO Has your child ever had a head injury?  
If YES, when \_\_\_\_\_

YES  NO Has your child ever been hospitalized? If yes, please state why and how long?

YES  NO Does your child appear to be very different from your other children, in his/her behavior, learning skills, or other skills? If YES, please explain: \_\_\_\_\_

**EDUCATIONAL EXPERIENCE AT HOME:**

Please check those items available at home:

<input type="checkbox"/>	Television	<input type="checkbox"/>	Books	<input type="checkbox"/>	Tape Recorder	<input type="checkbox"/>	Stereo
<input type="checkbox"/>	Computer	<input type="checkbox"/>	Video Player	<input type="checkbox"/>	DVD Player	<input type="checkbox"/>	Radio

What activities does the family participate in together?

---

---

---

Have there been any important changes within the family during the last 3 years? (For example: job changes, moves, births, deaths, illnesses, separations, divorce, etc.)

---

---

---

With whom in the family is the student particularly close? \_\_\_\_\_

\_\_\_ YES \_\_\_ NO Has this student ever been separated from the family due to family problems, health reasons, etc? If YES, for what reason(s)?

How did the student react to the separation? \_\_\_\_\_

Describe the student's behavior at home with peers, siblings, neighbors, parents (For example: is he/she generally well-behaved, passive or aggressive, social or a loner, affectionate or withdrawn, etc).

---

---

What methods of discipline are used with this student at home? (For example: extra chores, early bedtime, removing privileges, rewards for good behavior, etc).

What is your child's reaction to discipline? \_\_\_\_\_

### PEER RELATIONSHIPS

Does the student prefer to play/socialize with: \_\_\_ Boys \_\_\_ Girls?

Does the student have friends:

His/her own age? \_\_\_ YES \_\_\_ NO  
Younger? \_\_\_ YES \_\_\_ NO  
Older? \_\_\_ YES \_\_\_ NO

What does the student do when not in school?

Indoors? \_\_\_\_\_

Outdoors? \_\_\_\_\_

\_\_\_YES \_\_\_NO Has your child ever mentioned problems with school? If YES, how does he/she feel about the problem? \_\_\_\_\_

\_\_\_YES \_\_\_NO Do you think your child has a problem in school?

If so, what? \_\_\_\_\_

\_\_\_YES \_\_\_NO If you think your child has a problem in school, have you shared those concerns with the school? \_\_\_\_\_

When did you first notice the problem? \_\_\_\_\_

When did you share your concern? \_\_\_\_\_

What do you think is causing the problem? \_\_\_\_\_

\_\_\_YES \_\_\_NO Does your child have a part-time job after school or on weekends? If yes, please specify: \_\_\_\_\_

If so, how many hours per week do they work? \_\_\_\_\_

If your child qualifies for service, what type of service do you think would best most helpful?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Interpreter (if appropriate)

\_\_\_\_\_  
Date

# PARENT INFORMATION FOR STUDENTS WITH COMMUNICATION CONCERNS

Student Name: \_\_\_\_\_  
(First) (Middle) (Last)

Birthdate: \_\_\_\_\_  
Month Day Year

Person Completing This Form: \_\_\_\_\_

## Communication Skills Information

Please describe your child's skill level in the following areas by checking the appropriate indication.

1-No Problem Noted    2-Minimal Problems Noted    3-Significant Problems Noted

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Met speech/language milestones                          | 1 | 2 | 3 |
| <input type="checkbox"/> Produces speech sounds correctly in words               | 1 | 2 | 3 |
| <input type="checkbox"/> Speaks fluently without repetitions and hesitations     | 1 | 2 | 3 |
| <input type="checkbox"/> Uses voice quality consistent wit age and gender        | 1 | 2 | 3 |
| <input type="checkbox"/> Uses correct grammar/sentence structure when speaking   | 1 | 2 | 3 |
| <input type="checkbox"/> Uses vocabulary appropriate to same age peers           | 1 | 2 | 3 |
| <input type="checkbox"/> Gains attention of parents/siblings                     | 1 | 2 | 3 |
| <input type="checkbox"/> Seeks help or clarification when needed                 | 1 | 2 | 3 |
| <input type="checkbox"/> Initiates interactions with parents                     | 1 | 2 | 3 |
| <input type="checkbox"/> Initiates interactions with other children              | 1 | 2 | 3 |
| <input type="checkbox"/> Uses facial expression and body language to communicate | 1 | 2 | 3 |
| <input type="checkbox"/> Responds to greetings and interactions with others      | 1 | 2 | 3 |
| <input type="checkbox"/> Starts a conversation                                   | 1 | 2 | 3 |
| <input type="checkbox"/> Takes turns in conversation                             | 1 | 2 | 3 |
| <input type="checkbox"/> Makes relevant comments                                 | 1 | 2 | 3 |
| <input type="checkbox"/> Asks relevant questions                                 | 1 | 2 | 3 |
| <input type="checkbox"/> Converses using complete thoughts                       | 1 | 2 | 3 |
| <input type="checkbox"/> Relates an event or story in sequence                   | 1 | 2 | 3 |

Please add any additional information concerning your child's communication skills that would be helpful for planning an appropriate evaluation:

---

---

---



DATE SENT:  SPEECH AND LANGUAGE  PSYCHOLOGICAL SERVICES  
 OTHER: \_\_\_\_\_

EVALUATION:  
 Initial Evaluation

Bandera ISD  
 P.O. Box 727  
 Bandera, TX 78003 - 830-460-3893

**NOTICE OF FULL AND INDIVIDUAL EVALUATION (FIE)**

NAME OF STUDENT	DATE OF BIRTH	ID#	Grade	MEDICAID#
CAMPUS				

We have carefully reviewed your child's/your school records, information from his/her/your teachers, and information you have shared with us. More information is needed to determine his/her/your needs and to plan an appropriate school program. You will also receive a form requesting your permission for the consent for evaluation.

**We want to do a Full and Individual Evaluation of your child/you for the following reasons:**

Before recommending this evaluation, we considered the following alternatives:

Description of other options considered:	Why Options were Rejected:

We want to address all the areas listed below. This information will help us learn more about his/her/your educational needs.

**LANGUAGE (COMMUNICATIVE STATUS)**

If your child/you know(s) more than one language, these tests will help us find out which is the best language for his/her/your learning. They will also let us know which language to use for all other testing. We want to find out how well your child/you understand(s) what is said to him/her/you and how well your child/you can express thoughts. If your child has/you have trouble speaking clearly, we may test him/her/you to find out what any speech problems may be. Some of the tests we may give are: Preschool Language Scale, Comprehensive Assessment of Spoken Language, Goldman-Fristoe Test of Articulation, and the Stuttering Severity Instrument.

**PHYSICAL (MOTOR ABILITIES, HEALTH, VISION, HEARING)**

We want to know if any physical or health problems make it difficult for your child/you to do his/her/your school work. We use health histories, medical reports, tests, and rating scales to evaluate the student's health and the physical status, motor coordination, and the visual-motor integration. Evaluation techniques may include: vision and hearing tests, medical examination by a physician, and the gross and fine motor tests.

**EMOTIONAL/BEHAVIORAL**

We want to know how well your child/you get(s) along with others at school and at home. We will collect information from you and his/her/your teachers. We may also use formal evaluation techniques such as the Child Behavior Checklist, the Million Adolescent Personality Inventory, the Child Depression Inventory, the Robert's Apperception Test, the Thematic Apperception Test, and the Rorschach.

**SOCIOLOGICAL**

We want to get information about your child/your home life and kinds of experiences he/she/you have (has) had in your family. To assist us, we ask you to complete the Health and Family Information form.

**INTELLECTUAL/ADAPTIVE BEHAVIOR**

We want to determine how well your child/you think(s), compared to others of the same age. We also want to find out how well your child/you take(s) care of himself/herself/yourself at home and at school. We may give tests and/or rating scales to evaluate the student's development in verbal abilities, and/or nonverbal abilities, and adaptive social behavior in the community. Examples of such evaluation techniques include the Wechsler Intelligence Scales, the Kaufman Assessment for Children, and the Vineland Adaptive Behavior Scales.

**EDUCATIONAL LEARNING COMPETENCIES (ACADEMIC PERFORMANCE)**

DATE SENT:  SPEECH AND LANGUAGE  PSYCHOLOGICAL SERVICES  
 OTHER: \_\_\_\_\_

EVALUATION:  
Initial Evaluation

**Bandera ISD**  
P.O. Box 727  
Bandera, TX 78003 - 830-460-3893

### NOTICE OF FULL AND INDIVIDUAL EVALUATION (FIE)

NAME OF STUDENT	DATE OF BIRTH	ID#	Grade	MEDICAID#
CAMPUS				

We want to find out how your child is/you are doing in reading, math, spelling, and other areas, including job-related skills, and assistive technology if appropriate. We want to determine what he/she/you know(s) and what he/she/you need(s) to learn.

We may also give such tests as: Woodcock-Johnson Psychoeducational Battery III, Wechsler Individual Achievement Test, a reading inventory, The Expressive One Word Picture Vocabulary Test, Oral and Written Language Scale, Kaufman Test of Educational Achievement, Comprehensive Receptive/Expressive Vocabulary Test.

Describe any other factors relevant to this proposal to evaluate (if applicable):

None known

Your rights were explained to you when you were/your child was initially referred for special education evaluation. Federal regulations require that parents and adult students be provided a full explanation of all procedural safeguards (rights) in their native language or other mode of communication upon initial referral for evaluation, parent request for evaluation, upon receipt of a request for due process, and thereafter once annually or upon parent request.

To obtain assistance in understanding this Notice, you may call the Texas Education Agency Hotline # 1-800-252-9668.

Date given: \_\_\_\_\_ To: \_\_\_\_\_

If you want more information or if you have any questions, please call: GALM, PATRICIA  
at Bandera ISD Special Education Department

Phone: 830-460-3893

NAME OF INTERPRETER, IF USED

DATE

SIGNATURE OF INTERPRETER, IF USED

DATE

Date Sent: \_\_\_\_\_

Initial FIE Due Date: \_\_\_\_\_

Reevaluation Consent Received: \_\_\_\_\_

Initial FIE Consent Received Date: \_\_\_\_\_

**Bandera ISD**  
P.O. Box 727  
Bandera, TX 78003 - 830-460-3893

**CONSENT FOR FULL AND INDIVIDUAL EVALUATION**

Student Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_

Campus of Enrollment: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ MEDICAID# \_\_\_\_\_

Bandera ISD must obtain informed consent prior to conducting a full and individual evaluation. If you indicate YES in response to all of the statements below and sign at the bottom, you will be giving your consent for a full and individual evaluation.

Please check the appropriate box by each statement, sign your name, and date and return this form to the school as soon as possible.

Yes  No I have received the Notice of Proposal to Evaluate dated \_\_\_\_\_ that describes the proposed full and individual evaluation, and have been fully informed of the full and individual evaluation process and why it has been recommended.

Yes  No I understand and give my consent for the full and individual evaluation of my child/me.

Yes  No I understand that my consent for a full and individual evaluation is voluntary and may be revoked at any time. However, that revocation is not retroactive (i.e. it does not negate an action that has occurred after the consent was given and before the consent was revoked).

Yes  No I give my consent for the full and individual evaluation to begin immediately by waiving the required five school day period between Notice of Proposal to Evaluate and initiation of the full and individual evaluation.

Yes  No The information provided to me has been provided in my native language or other mode of communication. If other than English, specify: \_\_\_\_\_

Additional Comments or Concerns:

If you want more information or if you have any questions, please call: GALM. PATRICIA at: Phone: 830-460-3893

\_\_\_\_\_  
Name of Parent, Guardian, Surrogate Parent or Adult Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Guardian, Surrogate Parent or Adult Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Interpreter, if used

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Interpreter, if used

\_\_\_\_\_  
Date

Bandera ISD  
P.O. Box 727  
Bandera, TX 78003  
830-460-3893

**RECEIPT FOR EXPLANATION OF PROCEDURAL SAFEGUARDS OF A PARENT WITH A CHILD WITH DISABILITIES IN SCHOOL** *as Required by Individuals with Disabilities Education Act (IDEA) 34 Code of Federal Regulations - Part 300*

**AND**

**A Guide to the Admission, Review and Dismissal Process** *as Required by Texas Education Code §26.0081*

Name of Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

This is to verify that I have received:

I understand that my rights include the right to receive:

A copy of the Notice of Procedural Safeguards: Rights of Parents of Students with Disabilities which informs me of my rights throughout the child/student-centered educational process. The procedural safeguards have been explained to me by (name/position/date entered in the first column of each section).

This and all other notices in the language I understand (primary language) or, if needed, a translation of such orally, in sign language, or in Braille as appropriate; and answers from school personnel to additional questions I may have. My signature below indicates that I initially received a copy of the Notice of Procedural Safeguards: Rights of Parents of Students with Disabilities on the date specified and that I understand its contents.

A copy of the A Guide to the Admission, Review and Dismissal Process which explains the process by which an individualized education program (IEP) is developed and the rights and responsibilities of a parent concerning the process.

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Signature of Parent/Guardian/Surrogate Parent/Adult Student)

\_\_\_\_\_  
(Position)

\_\_\_\_\_  
(Date signed)

\_\_\_\_\_  
(Date issued)

\_\_\_\_\_  
(Signature of Interpreter, if used)

\_\_\_\_\_  
(Name of Student's Current Campus)

\_\_\_\_\_  
(Date signed)