CALHOUN COUNTY PUBLIC SCHOOLS

MTSS

Student Intervention Team

Procedures

Fall 2022

STUDENT INTERVENTION TEAM PROCESS

A. Team Members

a. The composition of the SIT varies depending on the reason for the student's referral to the team. All teams should include the school guidance counselor, the student's general education teacher, a school administrator, and the parent of the student. Other members who may participate, based on the referral reason, include a special education teacher, speech language pathologist, ESOL teacher, school nurse, school interventionist, school based mental health counselor, school psychologist, Occupational Therapist, Physical Therapist and others at the team's discretion/invitation.

b. The principal designates the chair of the team.

B. Prior to an initial SIT meeting

a. Determine if English is the primary language of the student. If not, complete form 21 (English as a Second Language Student Study).

b. The General education teacher makes contact with parent to discuss area(s) of concern and completes Section A of the Referral/Evaluation Planning Team: A (SIT 1) and provides the completed document to the SIT chair.

c. The SIT chair (assistant principal, guidance counselor, other) reviews the referral for completeness, establishes the SIT folder and checks cumulative file for test scores and to determine if student has been in special education. If the file indicates that the student is in special education or has been in special education, the principal's designee contacts the appropriate special education teacher/speech therapist for follow-up.

d. The SIT chair completes the Social and Developmental History (SIT 2a) or Preschool Social & Developmental History (SIT 2b) with parent, and obtains parent release of information using the Parental Authorization for Release and Use of Information (SIT 3), and requests medical/health records if applicable. The designee completes the Consent to Bill Medicaid (SIT 4) and provides the parent with a copy of the Notification of use of Public Benefits (Medicaid) (SIT 4b). The SIT chair obtains parent Permission for Screening (SIT 5). The SIT chair also obtains copies of most recent standardized test scores, discipline records, and attendance records.

e. The Speech/language pathologist conducts screening and completes the bottom portion of the Screening Record Form (SIT 6).

f. The Nurse conducts vision and hearing screening and completes the top portion of the Screening Record Form (SIT 6).

g. A member of the SIT team completes and documents at least one 30 minute observation of the student and records the results on SIT Observation Form (SIT 7) for academic concerns or the ABC Observation Form: Antecedent-Behavior-Consequence form (SIT 8) for behavioral concerns.

h. The SIT chair completes SIT Meeting Request Form (SIT 9)

* If the SIT packet is a carryover from the previous school year, all documents should be no more than 12 months old.

C. Initial SIT Meeting

a. The SIT chair schedules the initial SIT meeting and invites the parents to participate in the initial SIT meeting using the Parent Invitation (SIT 10). When parents are not initially responsive to an invitation, at least two attempts to obtain parent participation in the initial SIT meeting (phone call, letter mailed home, home visit) must be made. These attempts are documented using Documentation of Attempts to Obtain Parent Participation (SIT 11).

b. SIT chair designates a team member to record minutes of the meeting using Student Intervention Team Minutes (SIT 12). The team reviews all the information in the student's SIT folder and brainstorms research/evidence based strategies and interventions (at least three interventions for each area of concern).

c. The team schedules a tentative date for the follow up team meeting to review the effectiveness of the interventions. The length of the intervention period should be determined by the team and may vary according to the needs of the student. The interventions should be implemented for a sufficient amount of time to give the intervention time to work.

D. Data Collection/Intervention

a. The team designates the person to implement the interventions (general education teacher, interventionist, other). The person implementing the interventions collects data to determine effectiveness of interventions in the areas of concern. The results of this progress monitoring will be reviewed at the next SIT meeting. Graphs and charts are useful tools to document the effectiveness of the interventions.

b. For students whose primary language is not English, the general education teacher completes the English as a Second Language Student Study (SIT 21).

c. Additional data collection for behavioral concerns:

1. The team may decide to conduct a functional behavior assessment documented on the Functional Behavioral Assessment (FBA) (SIT 13).

2. Based on the results of the FBA, the team may need to develop a behavior intervention plan documented on the Behavior Intervention Plan (BIP) (SIT 14).

3. Additional documentation of behavior may include use of the Scatter Plot Form (SIT 15), Behavioral Graphing (SIT 16), and the Duration Data Recording Form (SIT 17).

d. The interventions are documented on the Student Intervention Plan (SIT 18) and include:

1. A quantitative description of the student's current performance
2. Measurable Goals or objectives in the area of concern
3. A description of the intervention(s)
4. Person responsible for the intervention
5. Frequency of the intervention
6. Date initiated
7. Progress monitoring outcomes with documentation

E. Second SIT Meeting

a. The person implementing the interventions presents student data to the team. The team reviews the results of the interventions and determines if the progress monitoring indicates a need to continue the interventions, revise the interventions, or take additional action.

b. If the data indicate that the student is making significant progress, the team may decide to continue the interventions and remove the student from the SIT process.

c. If the data indicate a need for continuing the interventions but making modifications to them, the team completes the Student Intervention Plan: Modified (SIT 19). A third SIT meeting must be scheduled to review the results of the modified interventions to determine further disposition of the case.

d. If the data indicate that the interventions are not producing significant progress, do not need to be further modified, and the team suspects the student may have a disability that is preventing the interventions from being effective, the team may refer the student for an initial evaluation to determine eligibility for special education.

e. The team completes the SIT Process Checklist (SIT 20) to document the activities of the team and provides the checklist to the school psychologist who will proceed with an evaluation planning team meeting.

F. Referral for Initial Evaluation

a. Referral for an initial evaluation should occur only when:

1. All required documents are completely filled out;
2. The student has passed vision and hearing screening;
3. The student has received at least 3 different interventions in the area of concern;
4. Modifications were made if the first 3 interventions were not effective; and
5. Intervention data indicate that the student made no significant gain.

b. The team has reason to suspect that the student may have a disability under IDEA.

* *c. For students who have a current speech language IEP, a referral to the SIT process triggers the reevaluation process rather than the SIT process. The IEP team which must include the speech language pathologist convenes to discuss the reason for the referral and determines what additional information

needs to be collected. Procedural safeguards and Prior Written Notice (PWN) must be provided to the parents in this process.

List of SIT Forms

SIT Request Form (SIT 1)
Social and Developmental History (SIT 2a)
Preschool Social and Developmental History (SIT 2b)
Parental Authorization for Release and Use of Information (SIT 3)
Consent to Bill Medicaid (SIT 4a)
Notification of use of Public Benefits (Medicaid) (SIT 4b)
Permission for Screening (SIT 5)
Screening Record Form (SIT 6)
SIT Observation Form (SIT 7)
ABC Observation Form: Antecedent-Behavior-Consequence Form (SIT 8)
Referral / Evaluation Planning Team: B (SIT 9)
Parent Invitation (SIT 10)
Documentation of Attempts to Obtain Parent Participation (SIT 11)
Student Intervention Team Minutes (SIT 12)
Functional Behavioral Assessment (FBA) (SIT 13)
Behavioral Intervention Plan (BIP) (SIT 14)
Scatter Plot Form (SIT 15)
Behavioral Graphing (SIT 16)
Duration Data Recording Form (SIT 17)
Student Intervention Plan (SIT 18)
Student Intervention Plan: Modified (SIT 19)
SIT Process Checklist (SIT 20)
English as a Second Language Student Study (SIT 21)

Request for Student Intervention Team Meeting

Section A: General Information to be completed by teacher

Student Name:	
School:	
Grade:	
Referring Teacher:	
Parent/Guardian:	
DOB:	
Date:	

Parent/Guardian contact prior to referral (include dates and method of contact):

Date	Method of Contact	Outcome/Notes

Reason for Referral (Primary Concern)

____ Academic ____ Behavioral

Check areas of difficulty for student:

READING	MATH	WRITTEN EXPRESSION	SPEECH/LANUGAGE	BEHAVIOR
○ Phonics ○ Fluency ○ Vocabulary ○ Comprehension ○ Other:	○ Calculation ○ Math Reasoning ○ Fluency ○ Problem Solving ○ Other:	○ Spelling ○ Fluency ○ Capitalization ○ Punctuation ○ Organization ○ Other:	○ Articulation ○ Oral Expression ○ Comprehension ○ Fluency ○ Other:	○ Attention ○ Hyperactivity ○ Aggression ○ Avoidance ○ Other:

Describe specific concerns for the request. What difficulties is the student experiencing in the classroom? List any academic, social, emotional, or medical factors that impact the student's performance.

How does the student's academic skills compare to those of an average student in your classroom?

In what setting/situations does the problem occur most often? Least often?

What are the student's strengths, talents, and interests?

Summary of classroom interventions utilized prior to the referral (i.e. small group, behavior charts, pull out with interventionist).

Student response to interventions (please include graphs, assessments, etc).

Has the student experiences frequent moves between schools or is there a history of family stressors?

Other pertinent information related to student's difficulties.

Referral Reviewed by SIT chair: _____ (Date)

- ○ Proceed with SIT Meeting
- ○ Returned to teacher for further completion

SIT 2a

Calhoun County Public Schools
St. Matthews, South Carolina

SOCIAL, HEALTH, and DEVELOPMENTAL HISTORY

Name: _____ Date of birth: _____ Age: _____ Gender: _____
School: _____ Grade: _____ Race: _____ SSN: _____
Home address where student currently lives: _____ Phone: _____
What are the present concerns of the parent and/or teacher in regards to this student?: _____
_____

I. DEMOGRAPHIC HISTORY:

Female Parent/Primary Caregiver
Name_____
Address_____
Home Phone _____ Work #_____
Cell Phone _____ Age_____
Occupation_____
Employer_____
Marital Status_____
E-mail Address_____

Male Parent/Primary Caregiver
Name_____
Address_____
Home Phone_____ Work #_____
Cell Phone_____ Age:_____
Occupation_____
Employer_____
Marital Status_____
Email Address_____

Name(s) of brothers and sisters, and any other children or adults living in the home	Relationship	Age	Education level (if in school)

How does the student get along with: (check as appropriate)

	Good	Fair	Poor	Comments
Father/Stepfather				
Mother/Stepmother				
Brothers/Stepbrothers				
Sisters/Stepsisters				
Other Children				
Other Adults				

Check the activities in which this student often participates with family:
☐ Movies ☐ Meals ☐ Church ☐ Visits with relatives ☐ Conversations
☐ Games ☐ Sports ☐ Trips ☐ Television ☐ Other, please list: _____

II. MEDICAL HISTORY:

Which of the mother's pregnancies was this child? (1st, 2nd, 3rd, etc.) _____
Check any of the following complications during this pregnancy:
☐ Anemia ☐ Measles ☐ German Measles ☐ RH Incompatibility ☐ Flu
☐ High Blood Pressure ☐ Toxemia ☐ Excessive Vomiting ☐ Excessive Bleeding ☐ Diabetes
☐ Abnormal weight gain ☐ Excessive swelling ☐ Emotional Problems ☐ Vaginal Bleeding ☐ Injury
☐ Cigarette use? _____ ☐ Alcohol use? _____ ☐ Other drug use? _____

Length of Pregnancy: ___ weeks Birth weight: ___ lbs. ___ oz. Length: ___ in. Length of labor: _____
Student's condition at birth: _____
Mother's condition at birth: _____
Length of time child in NICU: _____

Check any complications that occurred during birth:
☐ Forceps used ☐ Breech birth ☐ Labor induced ☐ Cesarean delivery ☐ Incubator, how long? _____
☐ Jaundiced, Bilirubin lights, how long? _____ ☐ Breathing problems, how long _____
☐ Other complications during delivery: _____

Child's physician's name: _____

Indicate if your child has/has had or receives/has received any treatment for any of the following.

☐ Anemia	☐ Diabetes	☐ Measles	☐ Mumps	☐ Seizures
☐ Asthma	☐ Allergies	☐ German Measles	☐ Tuberculosis	☐ Meningitis
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Frequent colds	☐ Encephalitis	☐ Diphtheria
☐ Any heart problems	☐ Verbal/motor tics	☐ Loss of consciousness	☐ Fevers above 104	☐ Tubes in ears
☐ Frequent ear infections	☐ Attention problems			

Give the age of occurrence, length, after effects of illness, etc._____

Has your child ever been on long-term medication? Yes No Please specify _____

Is your child currently on medication? Yes No Please specify _____

Has your child been diagnosed with any medical condition or genetic disorder? Yes No

If yes, please specify _____

Has your child ever had a neurological exam? Yes No Please Specify _____

Has your child ever had psychological counseling or therapy? Yes No Please specify _____

Does your child receive any therapies such as physical, occupational, or speech-language therapy? Yes No

If Yes, where and how often?_____

III. DEVELOPMENTAL HISTORY:

At what age did this student first doe the following? Please indicate year/month of age.

Turn Over		Stand Alone		Speak first words	
Sit Alone		Walk Alone		Show interest in sounds	
Crawl		Walk up/down Stairs		Speak in sentences	
Feed self finger- foods		Bladder trained, DAY		Bladder trained, NIGHT	
Feed self with spoon		Bowel trained		Rode Tricycle	

Has the student ever experienced any problems/behaviors in the following areas?

☐ Walking Difficulties	☐ Temper Tantrums	☐ Underweight/Overweight problems
☐ Unclear Speech	☐ Failure to Thrive	☐ Difficulties learning to ride bike, skip, throw
☐ Eating Problems	☐ Excessive Crying	☐ Difficulties making friends with other children
☐ Sleep Problems	☐ Vision	☐ Difficulties forming relationships with teachers
☐ Hearing	☐ Separating from Parents	☐ Thumb Sucking

IV. COMMUNITY CONTACTS:

Has the student or family had contact with any community agencies? (Mental Health Center, Department of Social Services, Developmental Disabilities and Special Needs, Department of Juvenile Justice, BabyNet, Easter Seals, etc.) Yes No

V. EDUCATIONAL HISTORY:

Please indicate whether the student exhibits any of the following behaviors:

☐ Has a short attention span	☐ Has Fears	☐ Needs more help with school work than other children
☐ Unhappy most of the time	☐ Seems Impulsive	☐ Overreacts when faced with a problem
☐ Requires a lot of attention	☐ Enjoys active games	☐ Enjoys activities such as reading, drawing, writing

Please indicate any of the following that the student has experienced in school:

☐ Skipped a grade	☐ Disliked going to school	☐ Had frequent absences from school
☐ Had behavior problems	☐ Had emotional difficulties	☐ Changed schools several times in one school year
☐ Got poor grades	☐ Had difficulty with math	☐ Has been evaluated for Special Education
☐ Been retained	☐ Had difficulty with reading	☐ Had difficulty with written expression

☐ Other, please explain: _____

What are the student's strengths? _____

This Social, Health, and Developmental History documentation is an opportunity for your involvement and participation in the evaluation process. By signing below, you understand that the above information serves as parental input into the evaluation/educational planning process for my child.

Signature_____

Please check as appropriate: ( ) Parent ( ) Legal Guardian ( ) Primary Caregiver

Preschool Social & Developmental History

Section I: General Information

Child's name: _____ Gender (circle one): M F

Child lives with: _____ Date of Birth: _____

Person Completing Form: _____ Child's Health Care Provider: _____

Language spoken at home: _____ Insurance: _____

Primary language child speaks: _____

Female Caregiver

Relationship to Child:

____ Biological mother
____ Step-mother
____ Adoptive mother
____ Relative – Specify: _____
____ Guardian
____ Foster mother
____ Other – Specify: _____

Name _____

Address _____

_____

Age _____

Home # _____

Cell # _____

Work # _____

Occupation _____

Marital Status _____

Male Caregiver

Relationship to Child:

____ Biological father
____ Step-father
____ Adoptive father
____ Relative – Specify: _____
____ Guardian
____ Foster father
____ Other – Specify: _____

Name _____

Address _____

_____

Age _____

Home # _____

Cell # _____

Work # _____

Occupation _____

Marital Status _____

Brothers and Sisters:

Name	Age	Sex	Living at Home
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No

Other Persons Currently Living in the Home:

Name	Age	Sex	Relationship

Who does your child spend the most time with? _____

What are your child's favorite activities? _____

Do you have any concerns regarding your child's development? If so, please explain: _____

_____

When did you notice or have this concern brought to your attention? _____

Does your child differ noticeable from other children in his/her ability to:

Communicate with others	____ Yes*	____ No	*If **yes**, explain: _____
Complete tasks	____ Yes*	____ No	*If **yes**, explain: _____
Follow Directions	____ Yes*	____ No	*If **yes**, explain: _____
Play with others	____ Yes*	____ No	*If **yes**, explain: _____

What does your child do well? _____

Section II Child's Health History _____

Birth History:

Were any of the following present during the pregnancy, labor, or delivery? (Circle Yes or No)

Preterm Labor	YES	NO	Alcohol Exposure	YES	NO
Excessive Bleeding	YES	NO	Smoking	YES	NO
Illegal Drugs	YES	NO	Prescription Drugs	YES	NO
Illness / Fever	YES	NO	High Blood Pressure	YES	NO
Rash	YES	NO	Poor Weight Gain	YES	NO
Toxemia	YES	NO	Too Much Weight Gain	YES	NO
Diabetes	YES	NO	Other:	YES	NO
Physical Abuse	YES	NO			

Were there any complications during the birth of your child? ____ Yes* ____No

If **yes**, please explain, including length of hospital stay: _____

_____

Birth weight: _____ Was he/she premature ____ Yes* ____ No

*If **yes**, how many weeks early? _____

Did your baby pass the newborn screening test? ____ Yes ____ No

Did your baby have any of the following during the first few months of life? (Circle Yes or No)

Jaundice	YES	NO	Infection	YES	NO
Fever	YES	NO	Sever Irritability	YES	NO
Feeding Difficulties	YES	NO	Emergency Room Visit(s)	YES	NO

Please explain any "yes" answers:_____

_____

Give the approximate ages at which your child:

Sat up _____ Crawled _____ Walked alone _____ Was toilet trained _____

Spoke first words _____ Put words together in sentences _____

Temperament:

Does your baby enjoy cuddling? (circle one) YES NO SOMETIMES

Was your baby fussy? (circle one) YES NO SOMETIMES

Feeding:

Does your child have poor eating habits? (circle one) YES* NO

*If **yes**, please describe: _____

_____

Sleeping:

What time does your child typically go to bed at night? _____

Does your child have sleep difficulties?(circle one) YES* NO

* If **yes**, please describe: _____

_____

Medical History:

Please list any surgeries, hospitalizations, accidents or injuries your child has had:

	What	Where	When
Surgeries			
Hospitalizations			
Accidents			

How would you describe your child's present health? _____

_____

Has your child been diagnosed with a medical condition (i.e., ADHD, Asthma, etc.)? (circle one) YES* NO
* If yes, please list conditions(s) _____

_____

Is your child currently taking any medication(s)? (circle one) YES* NO
* If yes, please list medication(s) and purpose: _____

_____

Is there a history of immediate family medical or mental health problems (i.e., Bipolar, Depression, Multiple Sclerosis, Cancer, Learning and/or Speech / Language / Communication Problems, etc.)? (circle one) YES* NO
* If yes, please explain: _____

_____

Has your child had a history or been treated for the following? (circle YES or NO)

Preterm Labor	YES	NO	Alcohol Exposure	YES	NO
Excessive Bleeding	YES	NO	Smoking	YES	NO
Illegal Drugs	YES	NO	Prescription Drugs	YES	NO
Illness / Fever	YES	NO	High Blood Pressure	YES	NO
Rash	YES	NO	Poor Weight Gain	YES	NO
Toxemia	YES	NO	Too Much Weight Gain	YES	NO
Diabetes	YES	NO	Other:	YES	NO
Physical Abuse	YES	NO			

Please list the following information for your child's current physician:

Name: _____ Address: _____

Phone number: _____

Section III Family's Health History

Has anyone in the child's family (parents, grandparents, aunts, uncles, cousins, or brother / sisters) been diagnosed with or treated for any of the following? (circle YES or NO)

Abuse	YES	NO	Hearing Problems	YES	NO
Allergies	YES	NO	Heart Condition	YES	NO
Birth Defects	YES	NO	Hormone Problems	YES	NO
Blood Disorders	YES	NO	Joint / Bone Problems	YES	NO
Cancer	YES	NO	Lung / Breathing Issues	YES	NO
Abdominal Pain	YES	NO	Drug Abuse	YES	NO
Alcoholism	YES	NO	Muscle Problems	YES	NO
Anemia	YES	NO	Bipolar Disorder	YES	NO
Ear Infections	YES	NO	Seizures / Convulsions	YES	NO
Eating Issues	YES	NO	Skin Problems	YES	NO
Down's Syndrome	YES	NO	Repetitive Movements	YES	NO

Autism	YES	NO	Vision Problems	YES	NO
ADHD / ADD	YES	NO	Schizophrenia	YES	NO

Comments:

Parent Name:_____

Parent Signature:_____ **Date:** _____

9IT3

CALHOUN COUNTY PUBLIC SCHOOLS

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Pupil's Name _____
First Middle Last

Address: _____ Telephone: _____

Date of Birth: _____

I hereby authorize disclosure of the following protected health information from the medical records of the above named student.

Name of **Person/Facility Authorized to RELEASE** information: _____
_____
_____

Name of **Person/Facility Authorized to RECEIVE** information:

Shalanda Shuler, Ed.S, NCSP
School Psychologist II
P.O. Box 215
125 Herlong Ave.
St. Matthews, SC 29135
E-mail: slshuler@ccpsonline.net
Phone: (803) 655-2626
Fax: (803) 655-7276

Jennifer Lincoln, School Psy.D.
School Psychologist III
P.O. Box 215
125 Herlong Ave.
St. Matthews, SC 29135
Email: jlincoln@ccpsonline.net
Phone: (803) 655-4007
Fax: (803) 655-7276

Meg Oakley, Ed.S
School Psychologist II
P.O. Box 215
125 Herlong Ave.
St. Matthews, SC 29135
Email: moakley@ccpsonline.net
Phone: (803) 655-2614
Fax: (803) 655-7276

Purpose of Disclosure: _____

Dates of Treatment: _____

Information to be Used/Disclosed - Medical Records, educational records, mental health records.
Other: _____

I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, communicable diseases including HIV/AIDS this information will be included as part of my medical record to the above -named person/facility.

The provider may not condition treatment on signing this authorization.

This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative, provided that the cancellation is made in writing except to the extent that:

1. The facility has already acted on your request prior to receiving the request to cancel the authorization; or
2. This authorization will automatically expire in 90 days unless otherwise stated.

Expiration Date: _____

_____ _____
Signature of Patient or Legally Qualified Representative Date

_____
Relationship of Legally Qualified Representative

The School District of Calhoun County
125 Herlong Avenue, P.O. Box 215
St. Matthews, SC 29135
Phone (803) 655-7310 * FAX (803) 655-7276

Consent to Bill Private Insurance and Medicaid

The Calhoun County School District and the South Carolina Department of Education (SCDE) have my permission to provide services to my child and release and exchange medical, psychological, and other personally-identifiable confidential information, as necessary, to the South Carolina Department of Health and Human Services (SCDHHS) and any applicable third-party insurer regarding billable services provided to my child. I understand the purpose of this consent is to bill Medicaid and/or private third-party insurer for services under the Individuals with Disabilities Education Act (IDEA).

By signing this form, I give the District and the SCDE my permission to bill and receive payment from Medicaid and any third-party insurer for diagnostic and psychological evaluation services, behavioral health services, nursing services, and other health-related screenings and treatment services billable to Medicaid or a third-party insurer with or without the requirement of an individualized education program (IEP). The District provided me written notification consistent with the IDEA regulation at 34 C.F.R. §§ 300.154(d)(2)(v) and 300.503(c), prior to my signing this consent to release information to bill Medicaid or any third-party insurer and prior to accessing Medicaid or my child's third-party insurance benefits.

I further understand that the District must provide me annual written notification of my rights relative to Medicaid or any third-party insurer accessing my child's information and before the District and the SCDE access my benefits to pay for services under the IDEA. This consent for release of information to bill Medicaid and any third-party insurer is a one-time consent and is not required annually thereafter, unless there is a change in the type or amount of services to be provided to my child or a change in the cost of the services to be charged to Medicaid or a third-party insurer. I understand that Medicaid and third-party insurance reimbursement for billable services provided by the District and the SCDE will not affect any other Medicaid services or insurance benefits for which my child is eligible. I understand that my child will receive the services listed in the IEP regardless of whether my child is covered by public or private insurance programs and regardless of whether I provide consent to access those benefits. I understand that my refusal to consent to the SCDHHS or any third-party insurer accessing my child's personally-identifiable information does not relieve the District of its responsibility to ensure that all required services in my child's IEP are provided at no cost to me.

I understand that this consent is voluntary on my part and may be revoked at anytime. If I later revoke consent, the revocation is not retroactive (i.e., it does not negate an action that occurred after the consent was given and before the consent was revoked).

I also understand that the District and the SCDE will operate under the guidelines of the IDEA and the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and provision of services.

Student's Name: _____ DOB: _____ Medicaid #: _____

_____ _____

Signature of Parent/Guardian Date

AREA MEDICAID PROVIDERS

HEARING SPECIALISTS

Carolina ENT
(Charleston ENT Associates, LLC)
832 Cook Road
Orangeburg, SC 29115
(803) 536-5511 Fax: 843-763-3834
Phone: 843-766-7103
www.carolinaentclinic.com

Midlands Hearing Associates
3 Richland Medical Park
Suite 130
Columbia, SC 29203
(803) 765-1919

SCENT (South Carolina ENT)
Locations:
Columbia – Downtown
Columbia – Northeast
Irmo
https://www.southcarolinaent.com/services/walk-in-clinic -- Medicaid plans accepted are listed on their website

ENT Lexington
Lexington Medical Park 2
146 East Hospital Drive
Suite 200
West Columbia, SC 29169
(803) 936-7530
https://www.entlexington.com -- They take Molina Medicaid and FirstChoice Medicaid and hearing screenings can usually be scheduled same day

Lake Murray Hearing
Lexington Office
150 Whiteford Way
Lexington, SC 29072
(803) 808-9611
https://lakemurrayhearing.com – They take FirstChoice and Healthy Connections Medicaid and have two locations

AREA MEDICAID PROVIDERS

HEARING SPECIALISTS

CENTA Medical Group
Lexington Office
157 Corley Mill Road
Lexington, SC 29072
(803) 256-2483

Columbia Office
9 Medical Park Drive #510
Columbia, SC 29203
(803) 256-2483
https://centamedical.com – Accepted Medicaid plans are listed on their website

ENT for Kids
Fontaine Business Center
Phone: 803-457-8120
Fax: 803-457-8129
200 Arbor Lake Drive
Suite 120
Columbia, South Carolina 29223
https://entforkidssc.com/accepted-insurance - Accepted Medicaid plans are listed on their website

VISION SPECIALISTS

The Opti-Shop by H. Rubin	Edisto Vision Center
1331 Chestnut Street	915 John C. Calhoun S.E.
Orangeburg, SC 29115	Orangeburg, SC 29115
Phone: (803) 535-2000	Phone: (803) 536-3755
	Fax: (803) 747-7204
Robert Cress	
1605 Carolina Ave.	
Orangeburg, SC 29115	
(803) 534-2352	
Eye Associates of Cayce-West Columbia	
600 Knox Abbott Drive	
Cayce, SC 29033	
(803) 794-4444	
www.eyeassociatesofcayce.com	

Calhoun County Public Schools

Permission to Screen

Student's Name:_____ **School:**_____

Dear:_____

Your child has been referred for screenings because he/she appears to be experiencing difficulty which may be interfering with his/her academic progress.

Screenings are designed to help us understand why your child may be experiencing some problems at school. With your permission, we plan to conduct the following screenings:

Please check yes or no.

Area to be screened:	**Yes**	**No**
Vision		
Hearing		
Speech		

This is not a referral of special education. However, if the screenings indicate that a referral meeting is necessary, you will be notified.

Sincerely,

_____

SIT Chair

PLEASE CHECK ONE, SIGN AND RETURN TO ME AS SOON AS POSSIBLE

_____ I give permission for my child to be screened at school

_____ I **do not** give permission for my child to be screened at school

Parent Signature_____ Date_____

CALHOUN COUNTY PUBLIC SCHOOLS

SCREENING RECORD FORM

Child's Name: _____ B/D: _____ C.A.: _____

Speech-Language Therapist: _____ School: _____

AREA	SCREENING TEST(S) ADMINISTERED	RESULTS	INTERPRETTION	RXs / STATUS
VISTION Date: _____ Conducted by:	Distance Vision Uncorrected Corrected Right (OD) _____ _____ Left (OS) _____ _____ Both (OU) _____ _____	___ Pass ___ Fail ___ Recheck	__ No significate problem __ Deviant but functional for testing __ Vision problem should be considered in test selection/administration	__ No follow-up needed __ Follow-up already accomplished __ Follow-up / referral is needed
HEARING Date: _____ Conducted by:	Audiometric Screening R L 1000 Hz @ 20 db P F P F 2000 Hz @ 20 db P F P F 4000 Hz @ 20/25db P F P F	___ Pass ___ Fail ___ Recheck	__ No significate problem __ Deviant but functional for testing __ Hearing problem should be considered in test selection/ administration	__ No follow-up needed __ Follow-up already accomplished __ Follow-up / referral is needed

SPEECH – LANGUAGE SCREENING				
Date: _____ Primary Mode of Communication: _____ AAC System: _____ Other: _____				
Oral Peripheral	Oral Peripheral Examination (Structure Function)	___ Pass ___ Fail ___ Recheck	___ No apparent deviations ___ Deviant	__ No additional testing is indicated __ Further assessment is warranted __ N/A (Currently in tx)
Articulation/Phonology	_____	___ Pass ___ Fail ___ Recheck	___ No apparent deviations ___ Deviant	__ No additional testing is indicated __ Further assessment is warranted __ N/A (Currently in tx)
Voice	Speech Sample (Voice Analysis)	___ Pass ___ Fail ___ Recheck	___ No apparent deviations ___ Deviant	__ No additional testing is indicated __ Further assessment is warranted __ N/A (Currently in tx)
Fluency	Speech Sample (Fluency Analysis)	___ Pass ___ Fail ___ Recheck	___ No apparent deviations ___ Deviant	__ No additional testing is indicated __ Further assessment is warranted __ N/A (Currently in tx)
Language	Receptive: _____ Expressive: _____ Pragmatics: Pragmatics Checklist	___ Pass ___ Fail ___ Recheck ___ Pass ___ Fail ___ Recheck ___ Pass ___ Fail ___ Recheck	___ No apparent deviations ___ Deviant ___ No apparent deviations ___ Deviant ___ No apparent deviations ___ Deviant	__ No additional testing is indicated __ Further assessment is warranted __ N/A (Currently in tx)
Other		___ Pass ___ Fail ___ Recheck	___ No apparent deviations ___ Deviant	__ No additional testing is indicated __ Further assessment is warranted __ N/A (Currently in tx)

ATTENTION SPECIAL EDUCATION OFFICE:

_____ This student [is currently receiving] / [may qualify for] speech therapy. Please invite the speech therapist to all meetings.

_____ Please forward a copy of the psychological report to the speech-language therapist.

_____ Other: _____

Return to Chair by_____
(date)

SIT Observation

Student:_____ Teacher:_____ School:_____ Grade:_____

Date of Observation:_____ Observer's Name:_____ Place/Subject area Observed: _____

Time Observed: _____ to _____ Size of Group: _____ Area of Concern: _____

Directions:

The student should be observed (for a minimum of 30 minutes) by someone other than the current teacher or teacher's aide in an **academic setting in which the child is experiencing difficulty**. Observer must be a teacher, guidance counselor, administrator, or other certified personnel. Please specifically describe pertinent behaviors of the student (across all four areas) during the observation period.

Briefly describe the structure of the classroom: _____

_____

Academic:

_____

_____

_____

_____

Behavioral:

_____

_____

_____

_____

Peer interaction:

_____

_____

_____

_____

Student/Teacher Interaction:

_____

_____

_____ _____

Observer's Signature **Observer's Position**

ABC Observation Form

Antecedent-Behavior-Consequence

Student: _____ Observer: _____

Date: _____ Time: _____ Activity: _____

Context of Incident:

Antecedent:

Behavior:

Consequence:

Comments / Other Observations:

Observation Statement:

From the information above, write a brief summary statement that includes what sets off the behavior, the behavior in measurable terms, and what the student gains or avoids.

SIT MEETING REQUEST

Section B: To be completed by the team (with assistance from referring regular education teacher and any other school personnel involved)

Section B: To be completed by the team (with assistance from the referring regular education teacher and any other school personnel involved)

This information must be gathered BEFORE the first team meeting, so that the team may assess all areas of concern and develop research-based interventions, if not already in place, that appropriately address the referral concern(s). The School Principal will review each file to check that all materials have been received.

Please **check** below and **attach** copies of the following:

1. _____Permission to Screen form _____ Date parent signed

**Do not complete hearing, vision, and speech screenings until 'Permission to Screen' form is signed and returned by parent*

2. Results of Vision Screening (please attach copy of results):
_____ Passed _____ Failed

3. Results of Hearing Screening (please attach copy of results):
_____ Passed _____ Failed

4. Results of Speech Screening (please attach copy of results):
_____ Passed _____ Failed

Note: Steps 1-4 must be completed prior to completing steps 5-19
Proceed to steps 5-19 only after student has passed all screenings

If student *fails hearing and/or vision screening*:
SIT process is halted until an "outside" evaluation is completed by a vision specialist or audiologist (school personnel to follow-up)

If student *fails speech screening*:
SLP must wait to test student until final SIT decision
SLP is required to attend SIT meetings to assist in developing interventions to address language concerns

If student is currently receiving speech services, obtain copy of speech file from SLP. Consult with Speech/Language Pathologist at your school, SLP will initiate re-evaluation process. SLP will be the case manager if student is in speech.

5. _____ Parental Release of Information
6. _____ Social/Developmental History Form
7. _____ Most recent report card
8. _____ Progress Reports
9. _____ Work samples in area of concern
10. _____ Standardized Test Scores (e.g., MAP, PASS)
11. _____ Student schedule
12. _____ Attendance (Student has attended ___ of ___ days of school)
13. _____ Discipline Records
14. _____ Classroom observation
15. _____ Medicaid Release Form
16. _____ Medical/mental health records
17. _____ Copy of speech file if student is in speech
18. _____ Anecdotal records or data from classroom intervention strategies

Has the student been retained? _____Yes _____ No
If yes, what grade(s)? _____

Student's grades compared to previous years have:
_____ Improved _____ Remained the same _____ Dropped significantly

Is a language other than English spoken in the home? _____ Yes _____ No

If yes, what language? _____

Is the student receiving ESOL services? _____ Yes _____No
If yes, how many minutes per day? _____

If student is receiving ESOL services, please provide necessary information (*ESOL evaluation* and *home survey*)
Note: If student is receiving ESOL services, then ESOL teacher must attend SIT meetings.

Additional services student is receiving (please check all that apply)

_____ Reading Interventions (list)_____ How often? _____
_____ After school program: _____How often? _____
_____ Counseling: _____ How often? _____
_____ Nursing services: _____ How often? _____
_____ Academy of Math: _____ How often? _____
_____ Speech Therapy: _____ How often? _____
_____ 504 Plan: _____
_____ Other: _____

Parent Invitation

Referral / Evaluation Planning Team Meeting

Student Name:_____

Date:_____

Dear _____:

Our Student Intervention Team is meeting on _____ at _____ in_____
(date) (time) (location)

to discuss academic and/or behavioral strategies to help your child. We are inviting you to this meeting because your input is important in developing a plan to assist your child. If you can not attend this meeting and would like to reschedule for another date/time, please contact me at _____.

Thank you,

_____
Chair

Documentation of Attempts to Obtain Parent Participation in the Referral / Evaluation Process

Student	Parent	Date Notice Sent by Student	Date Notice Mailed Home	Date / Time Phone Call	Date Home Visit	Date Other	Comments

Student Intervention Team Minutes

School _____ Referring Person / Position _____

Student _____ Grade _____ Date of Meeting _____

Disposition of Case:

_____ Begin Interventions

_____ Continue Interventions

_____ Modify Interventions

_____ Continue Interventions / Dismiss from SIT

_____ Refer for Evaluation (Must have a minimum of 2 SIT meetings to review/modify interventions)

_____ Other: _____

_____

_____

Team Members	Position
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

-Complete SIT Form 18

CALHOUN COUNTY PUBLIC SCHOOLS

FUNCTIONAL BEHAVIORAL ASSESSMENT (FBA)

Legal Name of Student: _____ Date of Birth: _____

PowerSchool ID #: _____

INTRODUCTION TO STUDENT BEHAVIOR

Describe the student's typical behavior in all education related settings (e.g., his/her approach to tasks, expectations, supervision, interaction, directives, etc.). Describe the events necessitating an FBA at the time.

DATA COLLECTION

Data Sources:

- ☐ Records Review (permanent record, special education record)
- ☐ Informal Measures (teacher, parent, student record)
- ☐ Samples of Behavior (anecdotal reports/ABC/permanent products)
- ☐ Sample of Behavior (direct observations of frequency, rate, latency, duration, etc)
- ☐ Other (explain)

Description of the data collected, including the strategies employed and the results:

FINDINGS

Target behavior(s):

Target Behavior Setting(s):

Target Behavior(s) Antecedents:

Target Behavior(s) Consequence:

ANALYSIS

Hypothesis

Context Information

Recommended Replacement Behavior

Possible Strategies to Support and Reinforce Replacement Behavior

Function of the Target Behavior

FBA INFORMATION

Date Completed:

Evaluator(s)

CALHOUN COUNTY PUBLIC SCHOOLS

Behavioral Intervention Plan

Legal Name of Student: _____ Date of Birth: _____

PowerSchool ID #: _____

BEHAVIORAL INTERVENTION PLAN (BIP)

Summary Statement of Behavior Review

BEHAVIORS

Identify and Define the Target Behavior:

Baseline Data for Target Behavior (frequency, intensity, duration, etc.):

Additional Information regarding Target Behavior:

Target Behavior(s) Antecedents:

Identify the function of the Target Behavior:

Replacement Behavior: (Behavior that could meet the same function/need as the Target Behavior):

Describe the skills to be taught related to Replacement Behavior:

Frequency/Location/Persons responsible for providing instruction:

STRATEGIES AND INTERVENTIONS

Strategies and intervention that will be used to reduce target behavior and/or support and reinforce replacement behavior:

CRISIS PLAN

Is a Crisis Plan necessary?

Yes No

COMMUNICATION PROVISIONS

How will regular communication about the Behavior Intervention Plan take place among staff in the implementation?

How will Parent/Guardian be consistently informed of progress?

- ☐ Daily Checklist
- ☐ Point Sheet
- ☐ Email
- ☐ Weekly Note
- ☐ Other:

BEHAVIORAL INTERVENTION PLAN REVIEW DATES

Date:

OUTCOME

Once this action has been completed, enter the outcome/recommendation below:

SCATTER PLOT FORM

Student: _____ Observer: _____

Starting Date: _____ Target Behavior: _____

☐ High rate of behavior ☐ Low rate of behavior ☐ None of the behavior

Time in 5-minute intervals	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10

BEHAVIORAL GRAPHING

Student: _____ Behavior: _____

School: _____ Tracking Period: _____

INCEDENTS																
	15															
	14															
	13															
	12															
	11															
	10															
	9															
	8															
	7															
	6															
	5															
	4															
	3															
	2															
	1															
	0															
	Date	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F

INCEDENTS																
	15															
	14															
	13															
	12															
	11															
	10															
	9															
	8															
	7															
	6															
	5															
	4															
	3															
	2															
	1															
	0															
	Date	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F

DURATION DATA RECORDING FORM

Student: _____ Class: _____

Target Behavior/Objective: _____

Date	Incident	Start / End	Duration	Initials
	1			
	2			
	3			
	4			
	5			
	6			
	7			
	8			
	9			
	10			
	11			
	12			
	13			
	14			
	15			
	16			
	17			
	18			
	19			
	20			

Notes / Observations: _____

Student Intervention Plan

Current Student Performance *(Quantitative description of student's current performance)*	***Objective/Goal **** (Goal should be measurable and address area(s) of concern)	***Intervention***	***Person Responsible*** — Frequency of Intervention	***Date Initiated***	***Progress Monitoring Outcomes *****

*Goal Setting: Goal should be measurable and directly related to the referral area(s) of concern indentified above. The goal should measure the student's rate or level of improvement through Curriculum-Based Measures (CBMs), grades, etc.

** Please attach copies of progress monitoring documentation to this intervention plan

Student Intervention Plan: Modified

Current Student Performance *(Quantitative description of student's current performance)*	***Objective/Goal*** (*The goal should be measurable and directly related to the area (s) of concern)	***Modified / New Intervention***	***Person Responsible*** — Frequency of Intervention	***Date Initiated***	***Progress Monitoring Outcomes *****

*Goal Setting: Goal should be measurable and directly related to the referral area(s) of concern indentified above. The goal should measure the student's rate or level of improvement through Curriculum-Based Measures (CBMs), grades, etc.

** Please attach copies of progress monitoring documentation to this intervention plan

SIT Meeting Results:

Date of follow-up SIT meeting to review modified intervention data: _____

SIT Team Members	**Signature**	**Date**

SIT Referral Process Checklist

Student: _____ Teacher: _____ School:_____ Grade:_____

Contact Person:_____

Date completed packet sent to Julie Black: _____

Date Principal reviewed SIT packet:_____ Principal's signature:_____

*Send the packet to Julie Black at the District Office. Each referral packet **MUST** contain the forms listed below *in the order indicated.*

Check	Standard Packet Paperwork	Person Responsible
	SIT Referral Process Checklist (SIT 20)	Sit Chair
	Parent Invitation(s) (SIT 10)	Sit Chair
	SIT Team Referral (Part A) (SIT 1)	Classroom Teacher
	SIT Team Referral (Part B) **must include all documents from listed steps 7-19* (SIT 9)	Sit Chair
	Parental Release of Information (SIT 3)	Sit Chair/Parent
	Social and Developmental History (SIT 2b)	Sit Chair/Parent
	Permission for Screening(s) (SIT 5)	Sit Chair/Parent
	Vision Screening Results (SIT 6)	School Nurse
	Hearing Screening Results (SIT 6)	School Nurse
	Speech-Language Screening Results (SIT 6)	Speech-Language Pathologist
	Observation (SIT 7)	School Personnel
	Student Intervention Plan (SIT 18)	Developed by SIT
	Student Intervention Plan: Modified *(include if intervention plan was modified)* (SIT 19)	Developed by SIT
	SIT Recommendation (s)	Developed by SIT
	SIT Meeting Minutes(s) (SIT 12)	Developed by SIT
	ED (Behavioral Referral) Packet, also submit the following:	
	A 10-day record of behavior (*10 day *minimum*; the 10 days documented must fall within 30 calendar days)	
	Completed intervention plan targeting student's problem behavior	
	Data related to effectiveness of intervention plan used (at least 4 weeks)	
	Documentation that student's problem behavior has existed for a *minimum* of 4 months	
	ESOL Packet, also submit the following:	
	English as a Second Language Student Study (SIT 21)	
	Student Oral Language Matrix (SOLOM)	
	Other Language screening results (IPT and/or ELDA) available	
Other:		

ENGLISH AS A SECOND LANGUAGE

STUDENT STUDY

Name: _____ Age: _____ Grade: _____

Primary Language: _____

Other language spoken: _____

Parent occupation: _____ What age came to the US: _____

How long has this student been in the United States? _____

How long has the student spoken English? _____

How fluent is the student in English? _____

What is the primary language spoken at home? _____

Is English spoken at all at home? _____ What percentage of the time? _____

What language does student speak with friends outside of school? _____

Does student have siblings? _____ Are they more or less fluent in English? _____

How are siblings doing in school? _____

_____

Are siblings having the same problems this student is having? _____

WIDA Test Results

Proficiency score: _____

Listening score: _____

Speaking score: _____

Reading score: _____

Writing score: _____

Interpretation of score report and recommendation: _____

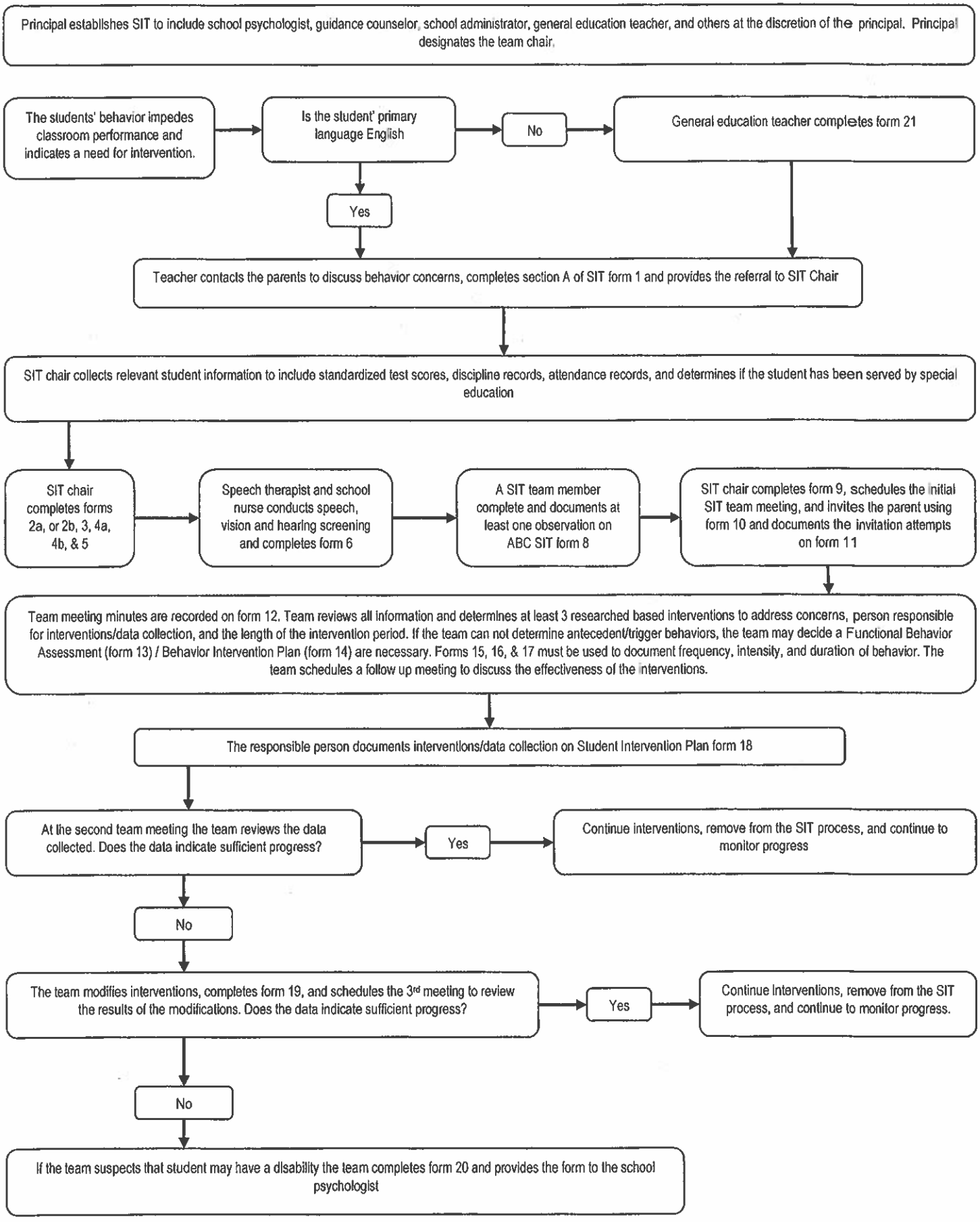
_____

_____

_____

Attach copy of WIDA and/or W-APT score report.

Spartanburg District 7 2016-2017 Student Intervention Team (SIT) Process for Behavior



November 2016