

STUDENT ENROLLMENT SCREENING

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Has the student ever received Special Programs or Services? (Circle all that apply)

Special Education

Gifted/Talented

Counseling

Title I

ESL

Advanced Classes

Remedial Classes

Speech Therapy

Physical Therapy

Occupational Therapy

Please answer the following questions to the best of your ability.

1. Describe the classes/program and the amount of time the student attended the special class. \_\_\_\_\_

\_\_\_\_\_

2. Does the student have academic or behavior problems? Please explain. \_\_\_\_\_

\_\_\_\_\_

3. Does the student have special health problems? Please explain. \_\_\_\_\_

\_\_\_\_\_

4. Has the student had any testing for Special Education? If so, when and where? \_\_\_\_\_

\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Office Use Only

No follow up needed

Student Referral/Copies distributed to:  SAT Chairperson  School Nurse  ELP Teacher

Speech Therapist  Special Education Teacher  Regular Education Teacher

Special Education Office  Other \_\_\_\_\_

Additional Referrals: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_