

**Wyoming Park High School**  
**Student Study Team Pre-referral Form**

Student: \_\_\_\_\_ Teacher(s): \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Grade: \_\_\_\_\_ Does the student receive special education service? \_\_\_\_\_

Check area(s) of concern:

Academic	Behavior	Health/Personal Care	Environmental Factors
<input type="checkbox"/> Reading <input type="checkbox"/> Math <input type="checkbox"/> Writing <input type="checkbox"/> Study Skills <input type="checkbox"/> Organization <input type="checkbox"/> Other _____  _____ GPA _____ PLAN _____ ACT _____ Credits Earned	<input type="checkbox"/> Aggressive <input type="checkbox"/> Noncompliant <input type="checkbox"/> Defiant <input type="checkbox"/> Work Completion <input type="checkbox"/> Attention <input type="checkbox"/> Poor attendance <input type="checkbox"/> Sad <input type="checkbox"/> Withdrawn <input type="checkbox"/> Anxious <input type="checkbox"/> Other _____ <i>Attach discipline referrals and/or attendance history if appropriate</i>	<input type="checkbox"/> Physical concerns <input type="checkbox"/> Visual concerns <input type="checkbox"/> Hearing concerns <input type="checkbox"/> Medication <input type="checkbox"/> Seizures <input type="checkbox"/> Fine/gross motor <input type="checkbox"/> Hygiene <input type="checkbox"/> Substance abuse <input type="checkbox"/> Other _____	<input type="checkbox"/> Trauma <input type="checkbox"/> Peers <input type="checkbox"/> Family <input type="checkbox"/> Work <input type="checkbox"/> Other _____

Check strategies tried thus far and circle those that have been successful.

General Prerequisites for SST Document results and contact dates	Suggested Interventions Not an exhaustive list	Suggested Interventions Not an exhaustive list
<input type="checkbox"/> Discuss with student _____ _____ <input type="checkbox"/> Discuss with parent _____ _____ <input type="checkbox"/> Consult PLC _____ _____ <input type="checkbox"/> Consult counselor _____ _____ <input type="checkbox"/> CA60 review _____ _____ <input type="checkbox"/> Other _____ _____ <i>The first five items must be completed prior to SST. SST will be scheduled by counseling office.</i>	<input type="checkbox"/> Planned seating <input type="checkbox"/> Reduce distractions <input type="checkbox"/> Provide time out area - as needed <input type="checkbox"/> Weekly grade sheets <input type="checkbox"/> Visual daily schedule/ assignments <input type="checkbox"/> Have student repeat directions/check for understanding	<input type="checkbox"/> Simplify directions <input type="checkbox"/> Peer tutoring <input type="checkbox"/> Note taking assistance <input type="checkbox"/> Allow for typed assignments <input type="checkbox"/> Shorten assignments <input type="checkbox"/> Small group instruction <input type="checkbox"/> Extended time <input type="checkbox"/> Tutor/mentor

Please include additional concerns, interventions, or information here:

---



---



---



---



---



---