

## REGULAR EDUCATION INTERVENTIONS CHECKLIST

Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_  
 Teacher \_\_\_\_\_

**The public agency must document a history of failed classroom interventions and / or programs which, however appropriate, proved ineffective, before referring a student for special education evaluation.** (Must document at least 2 interventions and /or programs were implemented.) (Must document and date that interventions and/or programs failed.)

Parents were notified of concern on: **Notification Date** \_\_\_\_\_ By \_\_\_\_\_  
 Primary language of student \_\_\_\_\_ Primary language in home \_\_\_\_\_

- If primary language is other than English, attach completed English language proficiency document. (Proficiency or Native Language was assessed and found adequate before referral.)

**Areas of Concern (check all that apply):** (Student must be assessed in each area related to suspected disability)

<u>Academic</u>	<u>Physical</u>	<u>Social/Emotional</u>	<u>Communication</u>
<input type="checkbox"/> Reading	<input type="checkbox"/> Hearing	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Articulation/ speech
<input type="checkbox"/> Math	<input type="checkbox"/> Vision	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Oral Language
<input type="checkbox"/> Spelling	<input type="checkbox"/> Fine Motor	<input type="checkbox"/> Peer Relationships	<input type="checkbox"/> Fluency / stuttering
<input type="checkbox"/> Writing	<input type="checkbox"/> Gross Motor	<input type="checkbox"/> Self image	<input type="checkbox"/> Voice
<input type="checkbox"/> Following directions	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Discipline	<input type="checkbox"/> Listening skills
<input type="checkbox"/> Study skills	<input type="checkbox"/> Hypoactivity	<input type="checkbox"/> Acting Out	<input type="checkbox"/> Other _____
<input type="checkbox"/> Attention span	<input type="checkbox"/> Self-help/adaptive	<input type="checkbox"/> Attention	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Physical handicaps	<input type="checkbox"/> Task Completion	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	

**Other Information:**

Name of Test \_\_\_\_\_ Results \_\_\_\_\_

Has this student ever received special education?     Yes     No    If Yes, when \_\_\_\_\_

Has student ever been retained?     Yes     No    If Yes, when \_\_\_\_\_

Date of Vision Screening \_\_\_\_\_     Pass     Fail    Action \_\_\_\_\_

Date of Hearing Screening \_\_\_\_\_     Pass     Fail    Action \_\_\_\_\_

Attendance:     Problem     No Problem    Comments \_\_\_\_\_

Health:     Problem     No Problem    Comments \_\_\_\_\_

Intervention	Date Begun	Date Ended	Comments/Data
Reading Recovery or Reading 180			
Title One			
Extended day			
ESL/ELL			
Student conference			
Teacher/student conference			
Parent conference			
Student contract (with student, parent or teacher)			
Parent involvement (as aide or at home)			
Parent intervention (phone call)			
Praise			
Increase positive comments			
Positive reinforcement			
Prompt reinforcement of correct responses			
Peer tutoring			

