GASCONADE COUNTY R-2 SCHOOL DISTRICT
402 East Lincoln I PO Box 536
Owensville, Missouri 65066

Office of Special Services
Housed in Owensville High School
3336 Hwy 19 I P.O. Box 536
Owensville, Missouri
Tami Bobbitt, Director of Special Services
Section 504 District Coordinator
(573) 646-4005, ext 1168
tbobbitt@dutchmen.us

Request for Consideration for Initial Special Education Evaluation

PARENT/GUARDIAN/CARETAKER REFERRAL- form revised 4/4/2023

STUDENT INFORMATION

Student's Name: _____ Date of Birth: _____

Age: _____ Grade: _____ If in Elementary School, Teacher: _____

Parent/Guardian Name: _____

Address:_____ email: _____

Home Phone: _____ Work or Cell Phone: _____

INDIVIDUAL MAKING THE REQUEST

Individual: _____ Role: _____

Date of request completed and submitted to building counselor: _____

Procedural Safeguards and Bill of Rights were given to the parent by: _____ date: _____

Method of Delivery: ❒ email ❒ in person ❒ sent home with student

BUILDING COUNSELOR REVIEW/ADMINISTRATION APPROVAL- or Office of Special Education if parent contacted OSS directly

Building Administrator: _____ date: _____

Building Counselor: _____ date: _____

Family Information: list those living in the home with the student

Name	Relationship to the student

DEVELOPMENTAL AND MEDICAL HISTORY

Describe any complications or unusual situations during the biological mother's pregnancy.
Ex. Was the student a multiple? Was the student born prematurely?

Describe any complications or unusual situations during delivery and/or birth.
Ex. Did the student experience a lack of oxygen? Did the student weigh less than four (4) pounds?

Were the student's infant, toddler, and preschool developmental milestones reached within expected ranges? If not, explain.

Is the student in overall good general health? If not, explain.

Has the student ever been hospitalized, had surgery, suffered from a childhood disease/ illness or been seriously injured? If yes, explain.

Does the student have a medical diagnosis or health condition? If yes, explain.

Does the student CURRENTLY take medication to address a medical diagnosis or health condition? If yes, explain.

Share any events that may be impacting the student while at school.
Ex. A recent death in the family. A divorce. Abuse from a family member.

EDUCATIONALLY RELEVANT HISTORY

List the Names of the Schools/Districts that your student has attended.

Has the student been retained? If so, what grade?

Share some of your child's strengths and things he/she does well.

Has the student previously participated or is currently participating in any of the programs/supports listed below?

___ Early Childhood Special Education
___ Therapies- speech, language, occupational, or physical
___ Section 504
___ Title Reading
___ Response to Intervention
___ Behavior Improvement Plan
___ Outside Services, such as counseling
___ other: _____

DESCRIPTION OF THE CONCERNS THAT PROMPTED THIS REQUEST- share concerns in each area
Questions listed are meant to prompt the parent to share relevant information

Describe <u>specific concerns</u> for the student in the areas that apply:

<u>VISION</u>**:** a student's near/far point visual acuity, eye muscle control, depth perception, color blindness, orientation/mobility skills.
→ Does the student wear glasses or corrective lenses?
→ Does the student use/need assistive technology to address vision deficits?
→ Is the student color blind?
→ Does the student experience difficulties with eye muscle control, orientation, or depth perception?

<u>HEARING:</u> a student's hearing acuity for pure-tones and speech, middle ear function, central auditory processing skills, and the need for/use of amplification systems**.**
→ Does the student wear hearing aids?
→ Does the student use an amplification device or use/need assistive technology to address hearing deficits?

<u>HEALTH:</u> a student's physiological and neurological condition to include metabolic functioning and/or evidence of disease or injury.
→ Does the student have any medical diagnosis or health conditions that you are aware of?
→ Has the child had any previous illnesses or injuries that affect him or her today?

***if addressed on the previous page, leave blank.**

<u>MOTOR:</u> a student's <u>gross</u> and <u>fine</u> motor skills to include laterality, directionality, balance, kinesthetic skills, tactile skills, ambulatory/postural problems and ocular motor coordination.
→ Is the student able to walk, run, jump, hop and climb playground equipment?
→ Does s/he participate in physical education without accommodations or assistance?
→ How is the student's handwriting to include formation, spacing, line adherence?
→ Is the student able to use scissors independently?
→ Is the student able to keep his/her place when reading?

_____

SPEECH: student's articulation or phonological skill, voice, or fluency.

→ Is the student able to correctly produce his/her speech sounds as expected for his her age?
→ Is the student's voice raspy or hoarse?
→ Is the student dysfluent or does s/he stutter?

LANGUAGE: student's receptive/expressive language skills, auditory processing.

→ Does the student initiate conversation with others?
→ Does the student make grammatical errors when speaking or writing?
→ Does the student understand and use age/grade typical vocabulary?
→ Does the student give direct answers to the question that was asked?

COGNITIVE: student's general mental abilities including learning rate, specific strengths and weaknesses, and sensory perceptual learning processes.

→ Is the student imaginative or creative?
→ Does the student have difficulty remembering things they have seen or heard?

ADAPTIVE BEHAVIORS: a student's ability to function and maintain self independently, and the degree to which the student meets satisfactorily the culturally imposed demands of personal and social responsibility.

→ Is the student able to complete self-care tasks, such as using the toilet, washing his/her hands, feeding him/herself and managing the tasks of eating in the cafeteria?
→ Does the student demonstrate environmental skills, such as navigating throughout the building?
→ Would s/he take action to protect themselves or seek assistance if they are injured or ill?
→ Does the student discriminate between safe and unsafe behaviors?
→ Is the student able to follow the routines and procedures of the school day?
→ Does the student have a sense of time? Ex. remembers that lunch is after recess?
→ Does the student initiate self-directed tasks when given the opportunity?

SOCIAL/EMOTIONAL/BEHAVIORAL: student's social/emotional/behavioral development in relation to learning, interpersonal relationships, and self.

→ Does the student maintain interpersonal relationships with peers and adults?
→ Is the student able to interpret emotional and social cues?
→ Does the student demonstrate an understanding of fairness and honesty?
→ Does the student interact appropriately with peers?
→ Does the student demonstrate a positive self-confidence or believe that s/he is a good person?

ACADEMIC: a student's educational skills and achievement levels including pre-academic skills, if age appropriate.

→ Does the student function on an academic level that is similar to his/her peers?
→ Can the student complete independent work with little to no assistance?
→ Does the student demonstrate strengths in one subject and weaknesses in another?

Is the student performing below expected achievement in either of the following:

⬜ Reading
If checked, indicate/describe below

→ Basic Reading Skill
To include: phonemic awareness, sight word recognition, phonics, and word analysis

→ Reading Fluency Skills
To include: reading with speed, accuracy, and proper expression

→ Reading Comprehension
To include: understanding and interpreting what is read

⬜ Written Expression
If checked, indicate/describe below
To include: transcription, handwriting, spelling, text generation and expressing thoughts in writing using the conventions of writing

---

⬜ Math
If checked, indicate/describe below

→ Mathematics Calculation
To include: counting, grouping objects, and computing math facts and completing mathematical operations

→ Mathematics Problem Solving
To include: defining a problem; determining the cause of the problem; identifying, prioritizing, and selecting alternatives for a solution; and implementing a solution

---

⬜ Listening Comprehension
If checked, indicate/describe below
To include: understanding and and making sense of spoken language

---

⬜ Oral Expression
If checked, indicate/describe below
To include: conveying wants, needs, thoughts, and ideas meaningfully

POST-SECONDARY TRANSITION: Age 16+ or younger, if appropriate.
→ Is the student able to keep their materials organized?
→ Does the student submit work within the timelines expected?
→ Does s/he work well with others?

ASSISTIVE TECHNOLOGY: a student's need for assistive devices/services in order to maintain, increase, or improve the functional capabilities of the student.
→ Does the student require a device to improve communication with others?
→ Does the student require the use of an ambulatory device in order to move from one part of the building to another?

If you have questions regarding the completion of this Referral for Consideration of Special Education, please reach out to your building counselor or administration.

Owensville Elementary School
Phone: (573) 646 4039
Tricia Ridder, Principal
Megan Young, Assistant Principal
Dawn Brune, counselor

Owensville Middle School
Phone: (573) 646-4038
Teresa Shulte, Principal
Kelly Brown, Assistant Principal
Mollie Maples, counselor

Gerald Elementary School
Phone: (573) 646-4041
Brad Royle, Principal
Jennifer Lindemeyer, counselor

Owensville High School
Phone: (573) 646-4005
Kris Altemeyer, Principal
John Bunch, Principal
Raquel Bunton, counselor
Kari Evans, counselor

Gasconade County R-II School District
Tradition- Pride- Excellence

At GCR2, we will inspire lifelong learners who are self-sufficient and ethical citizens.

THIS SECTION IS TO BE COMPLETED BY THE OFFICE OF SPECIAL EDUCATION ONLY

STUDENT INFORMATION

Student: _____ Date of Birth: _____

OFFICE OF SPECIAL SERVICES AGENCY/STAFF RECEIVING REQUEST

THIS SECTION IS TO BE COMPLETED BY THE OFFICE OF SPECIAL EDUCATION ONLY

Date Request received_____

Name of Agency staff who received request_____

DISTRICT DECISION REGARDING THE SUSPICION OF A DISABILITY

THIS SECTION IS TO BE COMPLETED BY THE OFFICE OF SPECIAL EDUCATION ONLY
Based upon the factors described above, the following decision has been made:

⬜ Disability is not suspected, inform the counselor, building administrator and the referring staff member that the request to test for special education was denied.

⬜ Disability may exist and is suspected, schedule a Review of Existing Data meeting within thirty (30 days of the Referral/Request to Test for Consideration of Special Education DATE received by Office of Special Education)

NAMES/ROLES OF PERSONNEL MAKING ABOVE DETERMINATION:

Individual	Role
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____