[School Letterhead]

Child Study Team Meeting Notes

Date: _____

Child's Name:_____ Grade/Class: _____
Classroom Teacher Name(s): _____

Staff in Attendance:

___ ___ ___
___ ___ ___
___ ___ ___*Teacher* _____
___*Teacher* _____ ___ *Other* _____ ___ *Other* _____

Reason for Referral:

_____
_____
_____

Parent Concerns:

_____
_____
_____

School Attendance: _____ %

Math Grade Equivalent: _____ *NYS CC Math Score: _____*

Reading Grade Equivalent: _____ *NYS CC ELA Score: _____*

Student Strengths:

_____
_____
_____

Student Weaknesses:

_____
_____
_____

Child Study Team Recommendations

Service	Provider	Duration	Service	Provider	Duration
AIS ELA			OT/PT Screening		
AIS Math			Hearing Screening		
After/Before School Support: ELA/Math			Speech Screening		
At Risk Services: ELA/Math			At Risk Counseling		
Sub-CSE Referral			Outside Agency Referral		

Person Responsible	Strategy/Next Step	Follow Up Date