FORM 16-1

Guam Department of Education
Child Study Team Referral
FORM ONE – A

CST REFERRAL: A Child Study Team (CST) referral is initiated when a student has been identified as needing additional supports based on academic, behavioral, social-emotional and other challenges. This CST Referral (Form A) and Parent/Guardian Information (Form B) can be completed by a teacher, parent/guardian, student, other school personnel, representatives of community agencies, or other individuals.

CST TIMELINES: Upon submission of this referral form to the School Administrator, a CST meeting shall take place no more than 30 working days from the date the referral submitted. If the referral is made within 30 working days before the last day of school, the CST Coordinator must ensure that a CST staffing takes place within 10 days after the beginning of the following school year.

Student Name: _____ **Student #:**_____ **DOB:** _____

Grade: _____ **School:** _____ **Referral Submission Date:** _____

Check all that apply:

❑ Academic	PowerSchool grades attached: ☐ YES ☐ NO
❑ Behavior	ODRs attached: ☐ YES ☐ NO
	PowerSchool Log Entries attached: ☐ YES ☐ NO
	OTRFs attached: ☐ YES ☐ NO **SARF attached:** ☐ YES ☐ NO
	PowerSchool Attendance attached: ☐ YES ☐ NO
❑ Health	Supporting documents attached: ☐ YES ☐ NO
❑ Social/Emotional	Supporting documents attached: ☐ YES ☐ NO
❑ Communication	Supporting documents attached: ☐ YES ☐ NO
❑ Fine/Gross Motor Skills	Supporting documents attached: ☐ YES ☐ NO
❑ Other: _____	

Write a brief statement about the concern(s):

_____

_____

_____

FORM 16-2

Guam Department of Education
Child Study Team Referral
PARENT/GUARDIAN INFORMATION
FORM ONE – B

Mother/Guardian Name: _____ Contact #: _____

Email: _____ Other Contact #: _____

Father/Guardian's Name: _____Contact #:_____

Email: _____ Other Contact #: _____

Home Address: _____

Mailing Address: _____

Is the parent/guardian aware of your concern? ❑ YES ❑ NO

If "No", explain _____

Does the student need an interpreter? ❑ YES ❑ NO Does the parent need an interpreter? ❑ YES❑ NO

Referring Individual Name and Relationship to Student: _____

Referring Individual Signature and Date: _____

FOR SCHOOL USE ONLY:

Date Received by School Staff:	School Staff Name & Signature:
Date School Administrator Received Referral:	School Administrator Name & Signature:
Name of CST Coordinator Assigned:	Date Received by CST Coordinator:

PARENT CONTACT LOG		
Date & Time:	**Form of Contact** (i.e. Phone, Email, Face-to-Face Meeting)	**Notes** (Person contacted, information discussed)

FORM 16-3

RESPONSE FOR ASSISTANCE: FORM TWO - A BEHAVIOR INFORMATION	**Student:** _____ **Student #:**_____

Information may be obtained by the school administrator or by reviewing the student's PowerSchool and/or PULSE, and CUMULATIVE file. This form is to be completed using the most current and relevant information.

School Administrator's Name: _____

A. Is communication with parent regular and consistent? ☐ YES ☐ NO

B. Student Conduct:

# of Office Discipline Referrals:	# of Suspensions:	# of DAC Hearings:
# of Absences:	# of Unexcused Absences:	# of Excused Absences: # of Tardies:
# of Office Truancy Referrals:	# of SARFs:	

Log Entries Attached: ☐ YES ☐ NO

C. Function of Behavior Assessment: ☐ YES ☐ NO

Date of the FBA: _____ FBA Attached: ☐ YES ☐ NO

Behavior Intervention Plan or Behavioral Management Plan: ☐ YES ☐ No

Date of the BIP/BMP: _____ BIP or BMP Attached: ☐ YES ☐ NO

D. Other Screeners/Assessments ☐ YES ☐ NO

If yes, specify Screeners/Assessments: _____ Date Completed: _____

Results of screener/assessment indicated above:

_____

_____

_____

E. Other Information

Provide details on other interventions that have been provided by school administration that may help in identifying what supports the student can benefit from:

_____

_____

_____

_____

_____

FORM 16-4

RESPONSE FOR ASSISTANCE: FORM TWO – B **SPECIAL PROGRAM INFORMATION**	**Student:** _____ **Student #:**_____

Information may be obtained from your ESL Coordinator, school counselor or from reviewing the student's PowerSchool/PULSE and CUMULATIVE file. This form is to be completed using the most current and relevant information.

ESL Coordinator or School Counselor's Name: _____

ESL: ☐ YES ☐ NO

Date of Entry to ESL Program: _____ Date of Student ESL Modification Form: _____

HLS attached: ☐ YES ☐ NO If no, why? _____

Primary Language: _____

LAS (*if applicable*) **are attached:** ☐ YES ☐ NO

List of ESL services provided: _____

Comments for ESL: _____

School Counselor

Has this student ever been retained? ☐ YES ☐ NO If "Yes", When?_____

Refer to GEBP 339: Promotion and Retention Early Granting of Credits.

Is there anything you know about the student's background, home situation or other factors that may contribute to the student's difficulties?

_____

_____

Supportive Counseling: ☐ YES ☐ NO
Comments for Supportive Counseling:

_____

_____

Other Screeners/Assessments: ☐ YES ☐ NO
If yes, specify Screeners/Assessments used: _____

Date completed: _____ Results of screener/ assessment indicated above: _____

FORM 16-5

RESPONSE FOR ASSISTANCE: FORM TWO – C **STUDENT HEALTH INFORMATION**	**Student:** _____ **Student #:**_____

School Health Counselor is to complete this form using the most current and relevant information.
School Health Counselor's Name: _____

Date of the Last Physical (within 12 months to be valid): _____

❑ Vision Screening Date (within 12 months to be valid): _____

☐ Passed ☐ Failed

- ☐ Follow-up needed: _____
- ☐ Wears glasses? □ YES □ NO
  Right: _____
  Left: _____

❑ Hearing Screening Date(within 12 months to be valid): _____

Tympanogram: ☐ Passed ☐ Failed

Pure Tone: ☐ Passed ☐ Failed

- ☐ Follow-up needed/comments: _____

Individualized Health Plan in place: ☐ YES ☐ NO

Other Screeners/Assessments ☐ YES ☐ NO

If yes, specify Screeners/Assessments used: _____
Date completed: _____

Results of screener/assessment indicated above: _____
_____
_____

Other medical information that may impact the student's ability to succeed (diagnosis/medication/allergies/etc.):

_____
_____

FORM 16-6

RESPONSE FOR ASSISTANCE: FORM TWO –D– 1 **PRESENT LEVEL OF ACADEMIC & FUNCTIONAL PERFORMANCE/ TEACHER WRITTEN INPUT**	**Student: _____** **Student #: _____**

Teacher is to complete this form using most current and relevant information.

Teacher's Name: _____

Class/Subject: _____

Student Work Samples Attached: □ **YES** □ **NO**

ACADEMICS

Current grade (percentage): _____ Is student achieving at grade-level? _____

Date of assessment: _____ Type of assessment:_____ Grade Level Equivalency: _____

Pre-Test Score: _____ Date: _____ Post-Test Score: _____ Date: _____

Reading: (fluency, reading rate, comprehension, etc.)
How many words can he/she read in a minute?_____ Number of errors?_____ Fluent? _____ Can he/she answer who, what, when, where, why and how questions in oral & written format?

Language Arts: (writing, spelling, etc.)
Can he/she write complete sentences? How's noun/verb agreement? Correct punctuation and capitalization? Can he/she write paragraphs? What type of words is he/she able to spell? Consonant-Vowel-Consonant, etc.?

Math: (problem solving, computations, etc.)
Can he/she: identify numbers?_____Solve word problems?
Can he/she add, subtract, multiply or divide?_____What kind of numbers? (Example: 2x2 digit with regrouping/renaming?)

Other subjects (Example: SC, SS, PE, CHAM, etc.):

FORM 16-7

RESPONSE FOR ASSISTANCE: FORM TWO –D– 2 **PRESENT LEVEL OF ACADEMIC & FUNCTIONAL PERFORMANCE/ TEACHER WRITTEN INPUT**	**Student: _____** **Student #: _____**

Social / Emotional Behavior:
Does he/she follow classroom/school rules? Does he/she get along with peers? How well does he/she adjust to changes? How well does he/she deal with stressful situations? Can he/she sit and attend to a task for the entire duration of task given? *Strengths:* *Areas for growth:*
Communication:
Can the student speak in complete sentences? How's noun/verb agreement? Can he/she express wants and needs in complete sentences?
Fine Motor Skills:
Can he/she manipulate writing objects with correct grasp?___ If not, how? Left/right handed? Does he/she put enough pressure when utilizing writing objects? Able to cut on line with scissors? What kind of lines? *****Submit work samples******
Gross Motor Skills:
Can he/she walk, run, jump, skip, climb, go up and down the stairs? Does he/she need to hold onto rail? Is he/she able to throw and catch a ball? Does he/she show motor control?
Self-care / Independent Living Skills:
Can child feed herself/himself? Dress/undress independently? Tie shoes? *Strengths:* *Areas for growth:* *List all interventions, modifications , and/or accommodations you use for the student to achieve success in the classroom:*

FORM 16-8

RESPONSE FOR ASSISTANCE: FORM TWO- E **OTHER PERSONNEL INFORMATION**	**Student:** _____ **Student #:** _____

The School Attendance Officer is to complete this form using the most current and relevant information.
School Attendance Officer's Name: _____

OTRFs attached: ☐ Yes ☐ No Comments:

_____

_____

SARF attached: ☐ Yes ☐ No
Comments:

_____

_____

Response to OTRF/SAR attached: ☐ Yes ☐ No

_____

_____

Truancy Checklist Results attached: ☐ Yes ☐ No
If yes, specify Screeners/Assessments used: _____ Date completed: _____
Results of screener/assessment indicated above:

_____

_____

The Social Worker is to complete this form using the most current and relevant information.
Social Worker's Name: _____

SPCE Support Services & Outreach Team Referral attached:
Comments: _____

SPCE Support Services & Outreach Team Response to Referral attached: ☐ Yes ☐ No
Comments:

_____

_____

Non-Instructional Personnel is to complete this form using the most current and relevant information. Non-Instructional Personnel's Name: _____
Supporting Documents attached: ☐ YES ☐ NO Comments:

_____

_____

FORM 16 - 9

CST COMMITTEE NOTICE: FORM THREE	**Student:** _____ **Student #:**_____

Date: _____

Identified Committee Members:

- ❑ Student
- ❑ Parents/Guardians (required)
- ❑ CST Facilitator – School Administrator (required)
- ❑ CST Coordinator – Certified personnel (required)
- ❑ General Education teacher(s) [must be the student's teacher(s)] (required)
- ❑ School Health Counselor
- ❑ School Counselor
- ❑ CRT/IEPC
- ❑ Referring individual
- ❑ Special Education/ESL teacher
- ❑ ESL Coordinator
- ❑ School Attendance Officer ❑ Social Worker
- ❑ Others (i.e. instructional coach, department chairpersons, itinerant teacher, one-to-one aide, etc.) ***There will be a*** ☐ ***CST Staffing for:*** ☐ ***CST Meeting for:***

Student Name: _____ **DOB:** _____

Grade Level: _____ **on (date)** _____**at (time)** _____ **in (room)** _____.

A referral was submitted on _____ in the area of:

- ❑ Academic ❑ Behavior ❑ Health ❑ Social/Emotional
- ❑ Communication ❑ Fine/Gross Motor Skills ❑ Other:_____

If there is an attachment for you to complete, please submit to _____ before the scheduled meeting. CST Coordinator

Thank you.

_____

School Administrator's Name and Signature

FORM 16-10

PLAN OF ACTION: FORM FOUR – A-1 ☐ **CST STAFFING** ☐ **CST MEETING (check one)**	**Student:** _____ **Student #:**_____

Date: _____ Time: _____ Location: _____

Committee Members Present (Print Name and Initial):

- ❑ Student _____
- ❑ Parents/Guardians (required) _____
- ❑ CST Facilitator – School Administrator (required)_____
- ❑ CST Coordinator – Certified personnel (required)_____
- ❑ General Education teacher(s) (must be the teacher(s) of the student) (required)

  _____ _____ _____ _____

  _____ _____ _____ _____
- ❑ School Health Counselor_____
- ❑ School Counselor_____
- ❑ CRT/IEPC_____
- ❑ Referring individual_____
- ❑ Special Education/ESL teacher_____
- ❑ ESL Coordinator_____
- ❑ School Attendance Officer_____
- ❑ Social Worker_____
- ❑ Others (i.e. instructional coach, department chairpersons, itinerant teacher, one-to-one aide, etc.)

  _____ _____ _____ _____

Agenda Part I

- ❑ Introductions
- ❑ Referring Individual
- ❑ Brief Statement about the Concern NOTES:

_____

_____

- ❑ Presentation of Responses for Assistance Forms
- ❑ Documentation of Intervention Strategies Implemented

Agenda Part II

After reviewing the student's existing data, work samples, and all information provided by parents/guardians, and the CST members, the committee makes the following **SUMMARY** regarding the targeted area(s) of concern and frequency/severity/duration. Additionally, the CST members have included information regarding the outcomes from the interventions attempted.

CST SUMMARY

1. AREA OF CONCERN:		
INTERVENTIONS IMPLEMENTED	**FREQUENCY/SEVERITY/DURATION INTERVENTION DATES**	**OUTCOMES**

2. AREA OF CONCERN:		
INTERVENTIONS IMPLEMENTED	**FREQUENCY/SEVERITY/DURATION INTERVENTION DATES**	**OUTCOMES**

3. AREA OF CONCERN:		
INTERVENTIONS IMPLEMENTED	**FREQUENCY/SEVERITY/DURATION INTERVENTION DATES**	**OUTCOMES**

☐Further Interventions/Accommodations

- ❑ Remedial Reading/Math
- ❑ Modified Curriculum
- ❑ Adapted Materials
- ❑ Tutoring
- ❑ Extended Time
- ❑ Other:_____
- ❑ Talking with parents/guardians
- ❑ Behavior Contract
- ❑ Monitoring Charts
- ❑ Timeout
- ❑ Repeated Directions
- ❑ Other:_____
- ❑ Detention
- ❑ Lost of Privileges
- ❑ Cooperative Learning
- ❑ Eliminate Distracters
- ❑ Preferential Sitting
- ❑ Other:_____

FORM 16-11

PLAN OF ACTION: FORM FOUR-A-2	**Student:** _____ **Student #:** _____

PLAN OF ACTION: SCHOOL-LEVEL INTERVENTION(S)

NOTE: Do not delay the implementation of this plan due to the parent's inability to meet.

Interventions Recommended at the 1st CST meeting	**Dates of Implementation** (Approx. 4-6 weeks in duration; indicate start and end dates)	**Outcomes To be discussed at the 2nd CST meeting**

Other recommendations (i.e. update physical exam, other evaluations, attendance referral, etc.)

_____

_____

_____

FORM 16-12

CHILD IDENTIFICATION CHECKLIST – FORM FIVE **(Completed by the teacher prior to the CST meeting)**	**Student:** _____ **Student #:** _____

Academics	**Yes**	**No**
Comprehends grade level texts and materials	❒	❒
Writes/prints legibly	❒	❒
Spelling is average	❒	❒
Copies information from the board easily	❒	❒
Identifies numbers	❒	❒
Writes numbers	❒	❒
Adds:	❒	❒
Subtracts:	❒	❒
Multiplies:	❒	❒
Divides:	❒	❒
Solves word problems	❒	❒
Tells time	❒	❒
Identifies coins and bills	❒	❒
Completes assignments on time.	❒	❒
Organizes school materials & assignments	❒	❒
Follows oral / written directions	❒	❒
Communication	**Yes**	**No**
Receiving ESL services	❑	❑
Has been seen or referred for ear, nose or throat problem?	❑	❑
Has known medical/emotional problems that may have an effect on speech?	❑	❑
Has been referred for or received speech and language services in the past?	❑	❑
Uses gestures to communicate	❑	❑
Articulation	**Yes**	**No**
Able to produce all age appropriate speech sounds clearly	❑	❑
Student's conversational speech is easily understood by the average listener	❑	❑
Student's speech is free of immature or "babyish" sounds		

Behavior	**Yes**	**No**
Brings appropriate materials to school	❒	❒
Asks questions	❒	❒
Changes activities without incident	❒	❒
Listens	❒	❒
Uses socially acceptable language	❒	❒
Demonstrates appropriate way for getting attention	❒	❒
Shares	❒	❒
Tells the truth	❒	❒
Gets along with peers	❒	❒
Participates in classroom activities	❒	❒
Follows rules of situation, activity or environment	❒	❒
Accepts responsibility for own behavior	❒	❒
Stays on tasks to completion	❒	❒
Works cooperatively	❒	❒
Controls anger	❒	❒
Gets along with adults (teachers, aides, etc.)	❒	❒
Consistently attentive	❒	❒
Language-Auditory Reception/Comprehension	***Yes***	***No***
Able to follow directions with no difficulty	❒	❒
Able to respond accurately to questions	❒	❒
Able to retain information given verbally	❒	❒
Sign Language	***Yes***	***No***
Uses formal sign language	❒	❒
Uses idiosyncratic or personalized signs	❒	❒

FORM 16-12

CHILD IDENTIFICATION CHECKLIST (continued)	**Student: _____** **Student #:_____**

Pragmatics	***Yes***	***No***
Stays on topic being discussed	❒	❒
Able to understand cause & effect	❒	❒
Makes eye contact when talking	❒	❒
Likes talking with people	❒	❒
Takes turns in conversations	❒	❒
Fluency/Stuttering	***Yes***	***No***
Speech rate is appropriate	❒	❒
Able to respond to discussion questions, and produce spontaneous expression without hesitations or repetitions.	❒	❒
Student is free of secondary signs of physical struggle when speaking (facial grimaces, eye or head jerks, rapid eye movements)	❒	❒
Motor Skills	***Yes***	***No***
Referred for physical therapy services in the past (Give date if yes):	❒	❒
Had orthopedic or neurological surgery. (If yes, describe in "any other" box below.)	❒	❒
Walks independently, without support.	❒	❒
Check any of the following used by the student: ❑ *Wheelchair* ❑ *Cane* ❑ *Walker* ❑ *Crutches* ❑ *Braces* ❑	❒	❒
Goes up and down stairs without help	❒	❒
Walks and runs with coordinated movements.	❒	❒

Voice	***Yes***	***No***
Has a physician referred this child for voice therapy?	❒	❒
Voice is free of hoarse, harsh or nasal qualities	❒	❒
Student is free of intermittent voice loss during speaking or reading	❒	❒
Visual Perception	***Yes***	***No***
Eyes work together normally	❒	❒
Copies from the board with ease.	❒	❒
Copies from book or paper with ease.	❒	❒
Uses letters or numbers age appropriately	❒	❒
Uses good posture for writing and reading	❒	❒
Socialization	***Yes***	***No***
Interacts appropriately with peers	❒	❒
Shares with peers appropriately	❒	❒
Control of anger and frustration is age appropriate	❒	❒
Initiates play with peers.	❒	❒
Responds appropriately to natural cues in the environment (peers, bell, clock, adult).	❒	❒
Works well in large group settings.	❒	❒
Able to take turns in group settings	❒	❒
Cognition	***Yes***	***No***
Has appropriate attention and/or concentration	❒	❒
Uses problem solving skills appropriately	❒	❒
Able to remember information	❒	❒

CHILD IDENTIFICATION CHECKLIST (continued)	Student: _____ Student #:_____

Tactile	*Yes*	*No*
Responds appropriately to touching objects or contact with people/environment	❒	❒
Can restrain from touching items that are "off limits"	❒	❒
Tolerates messy activities	❒	❒

Dressing, Hygiene, Toileting	*Yes*	*No*
Dresses and undresses like others of similar age	❒	❒
Washes/dries hands like others of similar age	❒	❒
Uses toilet independently.	❒	❒

If the Child Study Team's final decision to refer to Special Education, please indicate the areas of assessments for this child.

- ❑ Psychological Services
- ❑ Speech & Language
- ❑ DHHP
- ❑ Vision
- ❑ OT
- ❑ PT
- ❑ Leisure Education
- ❑ Emotional Disabilities
- ❑ Assistive Technology
- ❑ Autism
- ❑ Behavioral

FORM 16-13

CST REFERRAL DECISION-FORM SIX	**Student:** _____ **Student #:**_____

Dear Parent/Guardian,

Your child was referred to the Child Study Team (CST) at school due to issues regarding _____. Based on all the documentation, data, information, and other pertinent material, the CST is recommending the following:

☐ Child should be referred for possible evaluation by **Special Education.**
***Submit a completed copy of the CST Packet to the respective IEPC/CRT.**
DATE SUBMITTED:_____

☐ Child should be referred for possible referral for Section 504.
***Submit a completed copy of the CST Packet to the respective school counselor.**
DATE SUBMITTED:_____

☐ Child should be referred for evaluation by District Psychologist.
***Submit a completed copy of the CST Packet to the respective school counselor along with Permission to Evaluate see SOP 1200-019.**
DATE SUBMITTED:_____

☐ Child will be referred to Child and Adolescent Services Division (I Famagu'on-ta)
***Submit a completed copy of the CST Packet to the respective school counselor to initiate the Inadahi process. The appropriate Consent to Release Information MUST be signed by parent/guardian.**
DATE SUBMITTED:_____

☐ Child should be referred to an outside agency.
***Submit a completed copy of the CST Packet to the respective school-level designee, parent/guardian and appropriate agency. The appropriate Consent to Release Information MUST be signed by parent/guardian.**
DATE SUBMITTED:_____

☐ Documentation does NOT support the need for a referral at this time. The CST will develop alternative school-level intervention plans.
***Provide a completed copy of the CST Packet to the parent/guardian.**
DATE PROVIDED TO PARENT/GUARDIAN:_____

☐ If parent is not present at this meeting, referring teacher, or other appropriate school designee, will discuss this decision with parents and will explain options available to the parents/guardians.
***Provide a completed copy of the CST Packet to the parent/guardian.**
DATE INFORMATION WAS PROVIDED TO PARENT/GUARDIAN: _____

☐ Child will be retained in/promoted to the _____ grade level.
***Refer to BP339:** Promotion and Retention Early Granting of Credits

NOTE: All the original copies of the CST packet MUST be filed in the student's cumulative folder.

❒ Parent/Guardian refuses the CST Referral Decision as indicated above.

Reasons: _____

_____

_____ _____ _____

Parent/Guardian Print Name Parent/Guardian Signature Date

CST REFERRAL DECISION (continued)	**Student:** _____ **Student #:**_____

DATE: _____

CST MEMBER SIGNATURES:	**PRINT NAME**	**SIGNATURE**
Student	_____	_____
Parents/Guardians	_____	_____
CST Facilitator – School Administrator	_____	_____
CST Coordinator – Certified personnel	_____	_____
General Education teacher(s)		
(must be the teacher(s) of the student)	_____	_____
	_____	_____
	_____	_____
	_____	_____
School Health Counselor	_____	_____
School Counselor	_____	_____
CRT/IEPC	_____	_____
Referring individual	_____	_____
Special Education/ESL teacher	_____	_____
ESL Coordinator	_____	_____
School Attendance Officer	_____	_____
Social Worker	_____	_____

Others (i.e. instructional coach, department chairpersons, itinerant teacher etc.)

_____ _____ _____ _____

FORM 16-14

DEPARTMENT OF EDUCATION
OFFICE OF THE SUPERINTENDENT

www.gdoe.net
Telephone: 501 Mariner Avenue Barrigada, Guam
(671)300-1154/1536

PARENT/GUARDIAN NOTIFICATION FOR CHILD STUDY TEAM MEETING-FORM SEVEN

This is to inform you that a referral to conduct a Child Study Team (CST) has been made for your child. A CST referral is initiated when a student has been identified as needing additional supports based on academic, behavioral, social-emotional, and/or other challenges. The CST is designed to provide classroom teachers with instructional supports and strategies for helping students in need of assistance. The team of school-level professionals provide ideas to classroom teachers on methods for helping students experiencing academic or behavioral problems. To achieve this, schools collaborate with appropriate team members as well as research strategies that result in targeted, school-level interventions.

Your attendance, participation and input is greatly needed to ensure that your child is provided with appropriate interventions or referral (SPED, Section 504, outside agency) to support his/her success.

Student: _____ DOB: _____ Grade: _____School: _____

CST Meeting Details: Date_____Time_____Location_____

Your child was referred based on information/data concerning:

- ☐ Academic ☐ Behavior
- ☐ Health ☐ Social/Emotional
- ☐ Other: _____

Your signature indicates that you are aware of the CST meeting and that you agree to attend, participate, and provide valuable input as a member of your child's Child Study Team. Please sign and return to

_____. Is an interpreter needed for you? ☐ Yes ☐ No

_____ _____

School Administrator's Name and Signature **Parent/Guardian's Name and Signature**

If you are unable to attend, please indicate other dates and times when you are available below. A school official will contact you to confirm a date and time.

Parent/Guardian's Name and Signature: _____ **Date**: _____