

# Leola School District TAT Form

Student Name: \_\_\_\_\_  
Referring Person: \_\_\_\_\_

Grade: \_\_\_\_\_  
Meeting Date: \_\_\_\_\_  
Birth Date: \_\_\_\_\_

Parent has been informed of concerns:  YES or  NO;  
if yes, when was contact made: \_\_\_\_\_; how was contact made? \_\_\_\_\_  
Parent input: \_\_\_\_\_  
\_\_\_\_\_

## **FORM WILL NOT BE CONSIDERED WITHOUT PARENT CONTACT**

Known Medical Issues/ Diagnosis: \_\_\_\_\_  
Retained:  YES  NO  
If Yes, when: \_\_\_\_\_

### **Members in Attendance:**

General Education:	_____	_____
	_____	_____
	_____	_____
Special Education:	_____	_____
Administration:	_____	_____
Other:	_____	_____
	_____	_____

### **Areas of Concern:**

Academics:  Behavior:  Attendance:   
# of Late Assignments: \_\_\_\_\_ Absences/Tardies: \_\_\_\_\_

### **Student Strengths:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Current Grades:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **State/District Testing Results:**

Dibels: \_\_\_\_\_  
SBAC: \_\_\_\_\_  
Access: \_\_\_\_\_  
\_\_\_\_\_

**TAT Team Decision:** \_\_\_\_\_

**If Needed: Plan for Intervention:** \_\_\_\_\_

**Follow Up Date:** \_\_\_\_\_

**Academic Concerns**

- |  |  |
|--|--|
| <input type="checkbox"/> BASIC READING         | <input type="checkbox"/> MATH CALCULATION        |
| <input type="checkbox"/> READING FLUENCY       | <input type="checkbox"/> MATH PROBLEM SOLVING    |
| <input type="checkbox"/> READING COMPREHENSION | <input type="checkbox"/> WRITTEN EXPRESSION      |
| <input type="checkbox"/> ORAL EXPRESSION       | <input type="checkbox"/> LISTENING COMPREHENSION |

**OTHER ACADEMIC CONCERNS:**

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**Behavior Concerns**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Work Completion        | <input type="checkbox"/> Participation       | <input type="checkbox"/> Peer Relationships    |
| <input type="checkbox"/> Attention Span         | <input type="checkbox"/> Easily Distracted   | <input type="checkbox"/> Home Relationships    |
| <input type="checkbox"/> Organization           | <input type="checkbox"/> Verbally Disruptive | <input type="checkbox"/> Teacher Relationships |
| <input type="checkbox"/> Withdrawn              | <input type="checkbox"/> Motivation          | <input type="checkbox"/> Physically Aggressive |
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Asking for help     | <input type="checkbox"/> Following Directions  |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Impulsivity         | <input type="checkbox"/> Gives Up Easily       |
| <input type="checkbox"/> Hyperactivity          |  |  |
| <input type="checkbox"/> Other (specify): _____ |  |  |

\* How many times has the student been referred to the office? \_\_\_\_\_

**OTHER NOTES REGARDING BEHAVIOR:**

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**Attendance & Other Factors**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Frequent Tardiness     | <input type="checkbox"/> Frequent Absences                      | <input type="checkbox"/> Drop in Grades/ Low Achievement  |
| <input type="checkbox"/> Sleepy/ Lethargic      | <input type="checkbox"/> Mood Swings                            | <input type="checkbox"/> Recent death in immediate family |
| <input type="checkbox"/> Receiving Counseling   | <input type="checkbox"/> Previous Referral to Special Education |   |
| <input type="checkbox"/> Other (specify): _____ |   |   |

**OTHER NOTES REGARDING ATTENDANCE & OTHER FACTORS:**

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**Motor Concerns/Related Services**

- |   |  |
|---|--|
| <input type="checkbox"/> Gross Motor: _____ | <input type="checkbox"/> Fine Motor: _____   |
| <input type="checkbox"/> Language: _____    | <input type="checkbox"/> Articulation: _____ |
| <input type="checkbox"/> Counseling: _____  |  |

**OTHER NOTES REGARDING MOTOR CONCERNS/ RELATED SERVICES:**

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**Prior Accommodations/Interventions**

	Yes	No	Notes/Outcomes
Preferential Seating			
Frequent check-ins			
Repeating/Clarifying Directions			
Frequent prompting or redirection to task			
Read aloud to student (reading passage or directions)			
Multiplication Chart			
Calculator			
Visual supports			
Extended Time on Assignments or Tests			
Modified student work			
Other accommodations:			
1:1 intervention/ assistance			
Title Services in Math			
Title Services in Reading			
Behavior Intervention Plan			
Behavior Contract			
Behavior Chart			
Classroom Clip/Behavior Chart			
School Counselor Referral			
Other Academic or Behavior Interventions:			
Spoke with parent via telephone or e-mail			

**Any Additional Information:**