CHILD STUDY TEAM TRACKING FORM

20___ - ___ School Year Due Date:

Name of sutdent:	DOB:	Grade:	Sex: □ Male □ Female	□ District resident □ Open Enrolled
Parent or legal guardian:	Telephone number:		Address:	
Referred by:	Reason for Referral:			
Classroom teacher:	Special Education Case Manager:			□ Initial Evaluation □ Re-evaluation

□ Qualifies for Special Education services under: ____SLD ____E/BD ____ DCD ____OHD
____S/L ____TBI ____PI ____HI ____VI

□ Does NOT qualify for Special Education services

DATE	ACTION TAKEN