

## TEACHER NARRATIVE

### PERSONAL DATA

Child's Name:	Race:	Gender:	DOB:
District/School: RCSD/	MSIS #:	Grade:	Age:

### HOME AND FAMILY INFORMATION

Parent(s)/Guardian(s):

#### Language(s) Spoken in the Home

Is any language other than English spoken in the home?  Yes  No (skip to next section)

Language(s)	Child		Parent(s)/Guardian(s)	
	Understands	Speaks	Understands	Speaks
English				

#### History of Parent Contacts

Has the child's parent(s) requested a comprehensive evaluation or "testing" for the child verbally or in writing?  
 Yes  No

Have you contacted/been contacted by the child's parent(s) to discuss any concerns about the child's academic progress, development, and/or behavior?  Yes  No (skip to next section)

Date	Reason for Contact	Results

### REFERRAL INFORMATION

#### Child's Strengths

*Describe the child's strengths.*

#### Reason for Referral

*Describe any concerns that you have or any recent changes in the child's academic progress, development, or behavior (e.g., attendance, difficulties with school work, difficulties with adults or peers, changes in concentration or activity level, inattention, disruptive behavior, withdrawn, etc.)*

Has the child ever been evaluated/assessed/tested for special education?  Yes  No (skip to next section)

By whom: \_\_\_\_\_ When: \_\_\_\_\_  
 Results: \_\_\_\_\_

Has there been significant documented change in the child's home or school environment or overall adjustment?

Yes  No If yes, explain: \_\_\_\_\_

**Has the child's attendance been irregular?**  Yes  No If yes, explain: \_\_\_\_\_  
Number of schools attended: \_\_\_\_\_ Grades retained \_\_\_\_\_

**COGNITIVE AND ACADEMIC CONCERNS**

*Please attach any applicable academic records available that highlight your concerns about the child's cognitive and/or academic progress such as State and/or district-wide assessment data (MCT, PARCC scores), grade reports, universal screening data, Tier intervention records, progress monitoring charts, work samples, etc.*

**Cognitive Concerns**

**Can the child understand and follow directions?**  Yes  No  
**If yes:** Indicate:  One-step directions only  Two-step directions  Multi-step directions  
**If no:** Describe any additional support the child requires to understand and follow directions.

*Describe any concerns you have about the child's cognitive abilities.*

- commensurate with same age peers
- below same age peers. Explain: \_\_\_\_\_

**Academic Concerns**

**Indicate any academic areas in which the child is having difficulties:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Written expression      | <input type="checkbox"/> Basic reading skills  | <input type="checkbox"/> Math calculation     |
| <input type="checkbox"/> Listening comprehension | <input type="checkbox"/> Reading comprehension | <input type="checkbox"/> Math problem solving |
| <input type="checkbox"/> Oral expression         | <input type="checkbox"/> Reading fluency       |   |

*Describe the specific problems the child is having in any area(s) indicated.*

**Does the child know learning expectations (e.g., learning goals and demonstration of mastery)?**  Yes  No  
*Describe how you communicate these expectations to the child.*

**Indicate all instructional methods that engage the child and support his/her successful learning:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> independent seatwork      | <input type="checkbox"/> whole class instruction      | <input type="checkbox"/> cooperative/small group learning  |
| <input type="checkbox"/> independent reading       | <input type="checkbox"/> whole class discussions      | <input type="checkbox"/> small group activities/projects   |
| <input type="checkbox"/> child-directed activities | <input type="checkbox"/> highly-structured activities | <input type="checkbox"/> one-on-one/peer-assisted learning |

*Describe how the child participates in the classroom.*

**Can the child complete classroom assignments with typical instruction and guidance?**  Yes  No

*Describe the child's learning needs (compared to other children his/her age):*

- |   |   |   |   |
|---|---|---|---|
| How much explanation does s/he need?          | <input type="checkbox"/> less than most | <input type="checkbox"/> about the same | <input type="checkbox"/> more than most |
| How much guided practice does s/he need?      | <input type="checkbox"/> less than most | <input type="checkbox"/> about the same | <input type="checkbox"/> more than most |
| How much independent practice does s/he need? | <input type="checkbox"/> less than most | <input type="checkbox"/> about the same | <input type="checkbox"/> more than most |
| How much feedback does s/he need?             | <input type="checkbox"/> less than most | <input type="checkbox"/> about the same | <input type="checkbox"/> more than most |

*Describe the child's learning behaviors (compared to other children his/her age):*

- |   |   |   |   |
|---|---|---|---|
| How much initiative does s/he demonstrate?        | <input type="checkbox"/> less than most | <input type="checkbox"/> about the same | <input type="checkbox"/> more than most |
| How conscientious or attentive to detail is s/he? | <input type="checkbox"/> less than most | <input type="checkbox"/> about the same | <input type="checkbox"/> more than most |
| How much persistence does s/he demonstrate?       | <input type="checkbox"/> less than most | <input type="checkbox"/> about the same | <input type="checkbox"/> more than most |
| How often does s/he ask for assistance?           | <input type="checkbox"/> less than most | <input type="checkbox"/> about the same | <input type="checkbox"/> more than most |

Describe any additional support(s) and/or modification(s) the child requires to complete classroom assignments.

**Statewide and District Assessment Results**

Test	Date of Test ___/___	Date of Test ___/___	Date of Test ___/___
	Score	Score	Score
Reading/Language Arts	<input type="checkbox"/> MCT-2, PARCC <input type="checkbox"/> English II <input type="checkbox"/> MAAECF	<input type="checkbox"/> MCT-2, PARCC <input type="checkbox"/> English II <input type="checkbox"/> MAAECF	<input type="checkbox"/> MCT-2, PARCC <input type="checkbox"/> English II <input type="checkbox"/> MAAECF
Math	<input type="checkbox"/> MCT-2, PARCC <input type="checkbox"/> Algebra I <input type="checkbox"/> MAAECF	<input type="checkbox"/> MCT-2, PARCC <input type="checkbox"/> Algebra I <input type="checkbox"/> MAAECF	<input type="checkbox"/> MCT-2, PARCC <input type="checkbox"/> Algebra I <input type="checkbox"/> MAAECF
Science	<input type="checkbox"/> 5 <sup>th</sup> & 8 <sup>th</sup> grade Science Test <input type="checkbox"/> Biology I <input type="checkbox"/> MAAECF	<input type="checkbox"/> 5 <sup>th</sup> & 8 <sup>th</sup> grade Science Test <input type="checkbox"/> Biology I <input type="checkbox"/> MAAECF	<input type="checkbox"/> 5 <sup>th</sup> & 8 <sup>th</sup> grade Science Test <input type="checkbox"/> Biology I <input type="checkbox"/> MAAECF
Other	<input type="checkbox"/> 4 <sup>th</sup> & 7 <sup>th</sup> grade Writing Test <input type="checkbox"/> U.S. History	<input type="checkbox"/> 4 <sup>th</sup> & 7 <sup>th</sup> grade Writing Test <input type="checkbox"/> U.S. History	<input type="checkbox"/> 4 <sup>th</sup> & 7 <sup>th</sup> grade Writing Test <input type="checkbox"/> U.S. History

(ex. TABE, MAP, DRA, DAR, etc.)

Test:	Date of Test ___/___	Date of Test ___/___	Date of Test ___/___
	Score	Score	Score
Subject:			
Subject:			
Subject:			
Subject:			

**ADAPTIVE CONCERNS**

Describe any concerns you have about the child's adaptive functioning and daily living skills (e.g., self-care skills, community living skills, self-direction, etc.).

- commensurate with same age peers
- below same age peers. Explain: \_\_\_\_\_

**MEDICAL/PHYSICAL CONCERNS**

**General Health**

**Has the child had any significant medical conditions and/or accidents?**  Yes  No (skip to next question)  
 Describe any concerns.

**Does the child take any regular medications?**  Yes  No (skip to next question)  
 List and describe any side effects noted.

**Does the child receive physical or occupational therapy?**  Yes  No (skip to next question)

- PT – Frequency: \_\_\_\_\_ Location: \_\_\_\_\_
- OT – Frequency: \_\_\_\_\_ Location: \_\_\_\_\_

**Hearing and Vision**

**Indicate results of the vision and hearing screening:**

- Hearing Results:  pass  fail Date: \_\_\_\_\_
- Vision Results:  pass  fail Date: \_\_\_\_\_

**Does the child use devices to assist with hearing and/or vision?**  Yes  No (skip to next question)

Hearing aids (when acquired: \_\_\_\_\_)  Glasses (when acquired: \_\_\_\_\_)

**Does the child wear the device(s) on a regular basis in the classroom?**  Yes  No

### Motor Skills

*Describe any concerns you have about the child's fine motor skills (e.g., difficulty copying, spacing, writing within lines, grasping reflex, fastening clothes, etc.)*

commensurate with same age peers

below same age peers. *Explain:* \_\_\_\_\_

*Describe any concerns you have about the child's gross motor skills (e.g., hopping, jumping, balance, unusual gait, use of walker/wheelchair, etc.)*

commensurate with same age peers

below same age peers. *Explain:* \_\_\_\_\_

### COMMUNICATION CONCERNS

**Does the child receive speech or language therapy?**  Yes  No (skip to next question)

Frequency: \_\_\_\_\_ Location: \_\_\_\_\_

**What is the child's primary means of communication?**

Verbal  Gestures  Sign Language  Other: \_\_\_\_\_

**Does the child express his/her wants/needs/ideas appropriately for his/her age?**

Yes (skip to next question)  No *Explain:* \_\_\_\_\_

*Describe any additional concerns you have about the child's language or speech development and skills (e.g., voice is always hoarse/harsh/breathy, voice is too loud/soft, speaks too fast/slow, stuttering, etc.)*

### SOCIAL, EMOTIONAL, AND BEHAVIORAL CONCERNS

**Does the child know the classroom rules and behavior expectations?**  Yes  No

*Describe how you communicate these rules and expectations to the child.*

**Does the child receive social skills instruction or counseling services?**  Yes  No (skip to next question)

social skills instruction – frequency: \_\_\_\_\_

counseling services – frequency: \_\_\_\_\_

**Indicate if the child has had any of the following difficulties:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> difficulty making friends             | <input type="checkbox"/> being a victim of teasing/bullying       | <input type="checkbox"/> explosive/angry outbursts            |
| <input type="checkbox"/> aggression/fighting                   | <input type="checkbox"/> anxious in groups of people              | <input type="checkbox"/> obsessive/compulsive behaviors       |
| <input type="checkbox"/> withdrawn or keeps to self            | <input type="checkbox"/> fearful of speaking in social situations | <input type="checkbox"/> repetitive behaviors (e.g., rocking) |
| <input type="checkbox"/> inflexible/difficulty compromising    | <input type="checkbox"/> insensitive to others' emotions/needs    | <input type="checkbox"/> stealing or lying                    |
| <input type="checkbox"/> refrains from physical contact        | <input type="checkbox"/> does not interact well in groups         | <input type="checkbox"/> denies mistakes/blames others        |
| <input type="checkbox"/> engaging in teasing/bullying behavior | <input type="checkbox"/> cries easily or whines frequently        | <input type="checkbox"/> abusive to others                    |
| <input type="checkbox"/> extremely fearful or nervous          | <input type="checkbox"/> easily frustrated                        | <input type="checkbox"/> cheating on assignments/tests        |
| <input type="checkbox"/> depressed or very unhappy             | <input type="checkbox"/> suicidal thoughts                        | <input type="checkbox"/> defiance/oppositional behavior       |
| <input type="checkbox"/> self-injurious (e.g., cutting)        | <input type="checkbox"/> out of touch with reality                | <input type="checkbox"/> destructive behavior                 |
| <input type="checkbox"/> unwarranted self-blame/criticism      | <input type="checkbox"/> frequently complains of aches/pains      | <input type="checkbox"/> truancy/cuts classes                 |
| <input type="checkbox"/> does not speak in class               |   |   |

**Describe the child's behaviors (compared to other children his/her age):**

- |   |  |   |   |
|---|--|---|---|
| How active is the child?                  | <input type="checkbox"/> less active than others     | <input type="checkbox"/> about the same | <input type="checkbox"/> more active        |
| How well does the child pay attention?    | <input type="checkbox"/> less distracted than others | <input type="checkbox"/> about the same | <input type="checkbox"/> easily distracted  |
| How does the child handle change?         | <input type="checkbox"/> handles change easily       | <input type="checkbox"/> about the same | <input type="checkbox"/> resists change     |
| How does the child respond to new things? | <input type="checkbox"/> readily accepts new things  | <input type="checkbox"/> about the same | <input type="checkbox"/> resists new things |
| How strong are the child's emotions?      | <input type="checkbox"/> passive/indifferent         | <input type="checkbox"/> about the same | <input type="checkbox"/> very intense       |
| How moody is the child?                   | <input type="checkbox"/> very easygoing              | <input type="checkbox"/> about the same | <input type="checkbox"/> very changeable    |
| How predictable is the child?             | <input type="checkbox"/> unpredictable               | <input type="checkbox"/> about the same | <input type="checkbox"/> rigid routines     |

*Describe any additional concerns you have about the child's social/emotional/behavioral functioning.*

**Disciplinary Actions**

**Has the child ever:**

- been suspended from school?     Yes     No
- been expelled from school?     Yes     No

**\*\*Attach any office referrals or behavior logs.**

**Form completed by: (please print)**

**Date completed:**

**Form Updated by:**

**Date Form Updated:**

**Form Updated by:**

**Date Form Updated:**

**Characteristics: Please check those characteristics that the student exhibits consistently and in relation to the other students in your classroom. If the child exhibits none of the characteristics, check "no problems observed." Please circle the appropriate characteristic(s) if there are multiple options per item. Written explanation and/or additional explanation may be requested at the MET meeting.**

<b>General Physical</b> <input type="checkbox"/> <b>No problems noted.</b>		
Always complains of feeling sick	Takes prescription medicine	Has improper eye movements
Is continually thirsty	Wears glasses	Seizures observed in classroom
Has fluid draining from ears	Complains of double/blurred vision	Often has bruises on body
Wears hearing aids	Frequently squints/rubs eyes	Tics – involuntary movements/noises
Has frequent earaches	Eating problems	Has a serious illness
Complains of not being able to see the board	Holds printed material too close/too far away	Health problems that require special care
Other (Specify):		

<b>Gross Motor</b> <input type="checkbox"/> <b>No problems noted.</b>		
Difficulty going up/down stairs, alternating feet	Difficulty throwing a ball	Has unusual gait
Problems with lower body motor movement	Difficulty catching a ball	Problems with balancing
Problems with upper body motor movement	Difficulty hopping, skipping, or jumping	Uses walker/wheelchair
Other (Specify):		

<b>Fine Motor</b> <input type="checkbox"/> <b>No problems noted.</b>		
Problems with reaching/retaining motions	Problems with grasping reflex	Difficulty copying letters/numbers/words
Cannot transfer objects hand to hand	Difficulty holding crayon/pencil	Difficulty spacing
Difficulty cutting paper with scissors	Difficulty building a tower of blocks	Other (Specify):
Difficulty tying/buttoning/zippering	Difficulty staying in lines when writing	

<b>Social Skills</b> <input type="checkbox"/> <b>No problems noted.</b>		
Rarely interacts with others	Engages in rocking/repetitive movements	Does not join in group
Is frequently alone at lunch/recess	Unaware/takes no interest in other people	Does not share with others
Is frequently teased by others	Does not recognize another's feelings	Does not apologize
Usually withdraws from touch	Cannot deal with being left out	Does not express own feelings
Does not ask for help	Does not accept "no" as an answer	Other (specify):
Does not look at person talking	Does not accept consequences of own actions	

<b>Adaptive Behavior</b> <input type="checkbox"/> <b>No problems noted.</b>		
Need for a high degree of supervision	Unable to wash/dry hands independently	Not toilet trained
Immature for his/her age	Inadequate skills in exchange of money	Inadequate skills in telling time
Has only younger playmates	Inadequate skills in using telephone	
Constant thumb/finger sucking	Does not engage in independent community skills	
Constant hair chewing	Inadequate skills in appropriate personal hygiene	
Difficulty feeding self	Lacks daily living skills such as sweeping, mopping, using washer/dryer, etc.	
Other (Specify):		

<b>Behavior</b> <input type="checkbox"/> <b>No problems noted.</b>		
Unable to interact with minimal friction	Frequently quarrels, pouts, or sulks	Difficulty staying on task
Denies mistakes/blames others	Insults other students/adults	Easily frustrated
Prefers to be alone or isolated	Acts before thinking/impulsive	Easily loses temper
Frequently found to be untruthful	Yells at other students/adults	Teases others
Mute/refuses to speak	Fails to complete assignments	Bullies others
Threatens other students	Fails to turn in homework	Interrupts others
Puts down peers	Refuses to complete work	Fails to bring materials to class
Difficulty paying attention to a task, extracurricular activity, or academics		
Disciplinary actions have been initiated by principal or other school authorities		
Oppositional/resistant/noncompliant/negative/defiant		
Disciplinary actions initiated through juvenile court system		
Other (Specify):		

<b>Emotional</b> <input type="checkbox"/> <b>No problems noted.</b>		
Upset by ANY change in routine	Talks about suicide or death wishes	Unresponsiveness

Pronounced fear of failure	Exhibits unwarranted self-blame/self-criticism	Shows excessive fears of specific objects
Irritable for greater part of day	Performs obsessive/compulsive behaviors	Engages in self-destructive behaviors
Appears withdrawn from peers	Changes mood for no apparent reason	Rarely laughs or smiles
Depressed for most of the day	Creates imaginary/fantasy situations in an attempt to escape reality	
Has attempted suicide	Tells of extremely strange/illogical thoughts or fears	
Has experienced significant changes in activity levels or concentration or school grades or interests		
Other (Specify):		

<b>Receptive Language</b> <input type="checkbox"/> No problems noted.		
Difficulty comprehending new ideas	Does not understand vocabulary words related to the curriculum	
Does not comprehend questions	Does not understand age-appropriate vocabulary	
Does not understand spoken directions	Does not understand information in class that is presented orally	
Cannot identify simple objects	Does not follow multi-step directions	
Does not demonstrate use of position words such as on, under, front, behind, beside, over, etc.		
Other (Specify):		

<b>Expressive Language</b> <input type="checkbox"/> No problems noted.		
Difficulty organizing thoughts	Nonverbal	Uses oral grammar incorrectly
Does not use age appropriate grammar	Difficulty asking questions	Hesitant to engage in verbal interaction
Difficulty finding the right words	Silent much of the time	Difficulty giving directions
Does not tell definitions of words	Cannot retell a story	Difficulty telling a story
Difficulty putting thoughts down on paper	Does not use spoken compound sentences	Does not name objects/actions in pictures
Uses immature words	Uses immature sentence patterns	
Verbal responses do not relate to questions asked or subject under discussion		
Other (Specify):		

<b>Speech</b> <input type="checkbox"/> No problems noted.		
Articulation	Voice	Fluency
Substitutes one sound for another	Too loud or too soft	Rate of delivery too fast or too slow
Omits sounds	Consistently hoarse/harsh/breathy	Disruption in normal flow of speech
Distorts sounds	Nasal sounding – like a constant cold	Words prolonged
Difficulty sequencing sounds	Pitch too high or too low	Excessive repetition syllable/sound/word
Difficult to understand	Voice “lost” by end of or during day	Interferes with daily communication
Able to self-correct errors	Quality makes difficult to understand	Inserts unnecessary words into speech
Uses dialect	Quality resulting from culture	
If additional characteristics are noted in any area of speech, please specify:		

<b>Visual Perception</b> <input type="checkbox"/> No problems noted.		
Visual tracking difficulties	Transposes letters	Prefers auditory activities
Visually confuses objects/letters/numbers	Confuses left to right on pencil/paper activities	Difficulty identifying shapes in various sizes and positions
Difficulty discriminating between words with similar appearance	Difficulty completing missing details in objects or pictures	Difficulty in copying assignments from board to desk/book to paper
Continues to demonstrate difficulty in reversing or inverting letters of alphabet after age 6		
Other (Specify):		

<b>Auditory Perception</b> <input type="checkbox"/> No problems noted.		
Difficulty understanding spoken directions	Does not orally form phrase/sentence correctly	
Difficulty sounding out word, sound by sound	Does not retain auditory stimuli	
Difficulty identifying rhyming words	Other (Specify):	
Difficulty sequencing syllables/letters in speaking and/or reading and/or oral spelling		