

CA-60 Review

Name: _____ DOB: _____ Teacher/Counselor: _____ Grade: _____

Parent/Guardian/Foster Parent (circle one) Name: _____

Date of Review: _____

Most Current Medical Information

Hearing: Pass/Referred (circle one) Date: _____

Vision: Pass/Referred (circle one) Date: _____

Prescribed Glasses: Y/N (circle one) Does student wear them? _____

Medical Diagnosis/Concerns: _____

Medications: _____

Agency Services (private counselor, Community Mental Health, Probation Officer, etc.): _____

_____ Release of Info signed? Y / N (please attach)

Agency Service Provider: _____

School History (Elementary)

Year/Grade	Absences	Tardies	Teacher Comments (from journal/report card)	Services (academic support, School Social Work, Speech)

Retention: Y/N Grade: _____ Retention Recommended: Y/N Grade: _____

Placed vs. Promoted: Grade: _____

☐ Attendance concerns/ Actions taken: _____☐ Current Functional Behavior Assessment/Behavior Plan (attach) ☐ Behavior Plan Needed☐ 504 (attach plan) ☐ Spec Ed certified as: _____ (attach current IEP)

Interests/Hobbies: _____ Strengths: _____

Areas of Concern: 1) _____ 2) _____ 3) _____