TWEAK

Together We Educate All Kids

Student Support Team Form

Child's Name: _____ Date: _____ Grade: _____

Date of Referral: _____ Homeroom Teacher's Name: _____

Name of Referral Source: _____ What is the Relationship to child? _____

How long has referral source known this child? _____ Who is child's physician? _____

Barriers to Learning

Circle any that apply

Loses temper easily	Argumentative	Easily annoyed	Appears angry/resentful
Defies/refuses to comply with requests or rules	Difficulty sustaining attention in tasks	Teases others	Does not seem to listen when spoken to directly
Throws things	Tries to annoy others	Breaks things	Yells
Hits	Fails to complete work	Kicks	Calls names
Negative attitude	Critical remarks	Impolite	Disrespectful talk
Steals	Lies		

Health Concerns

Circle any that apply

Frequently tired	Lice	Often sick	Toileting

1. In your own words, describe your concerns for this child. Please also list which concern is your biggest concern if you have more than one.

2. What strategies have been used already to address these concerns?

3. Is there any additional information that should be discussed about this child or his/her situation or needs?