TURTLE RIVER MONTESSORI

excellence in whole education

STRATEGY INTERVENTION MEETING

Child's Name: _____ Age: _____ DOB: _____

Please Print

Parent: _____ Teacher: _____ Class: _____

Review Student History:

1. **Learning or behavioral concern:** ☐ **Yes** ☐ **No**
2. **Has the child had a vision screening?** ☐ **Yes** *(attach copy of report)* ☐ **No** ☐ **N/A**
3. **Has the child had a hearing screening?** ☐ **Yes** *(attach copy of report)* ☐ **No** ☐ **N/A**
4. **Has the child had an educational/behavioral evaluation?** ☐ **Yes** *(attach copy of report)* ☐ **No** ☐ **Unknown**
5. **Evaluation Requested?** ☐ **Yes** *Type:_____* ☐ **No**
6. **Has there been a previous meeting with TRM teachers?** ☐ **Yes** *(attach meeting notes)* ☐ **No**

Strategy Plan:

_____
_____
_____
_____
_____
_____
_____

Recommendations:

_____
_____
_____
_____
_____
_____
_____

Parents Comments:

_____
_____
_____

_____ _____ _____

Meeting Date ***Meeting Start Time*** ***Meeting End Time***

_____ _____

Parent Signature ***Teacher Signature***