

Classroom Response to Instruction/ Intervention (RtI)
Request for Assistance

Initiation Date _____ Student's Name _____ Student # _____ DOB _____
Teacher _____ Grade Level _____ Current School Year _____
Parent/ Family Contact _____ Relationship _____ Date of Contact _____
Instructional/ RtI Coach _____

ACADEMIC DATA

Lower 25th percentile: Reading? Y or N

Math? Y or N

Grades Previously Retained? _____

Absences: # in current year _____

Tardies: # in current year _____

Referrals: # in current year _____

FSA:

ELA _____

Math _____

i-Ready:

Reading _____

Math _____

Report Card Grades:

ELA _____

Math _____

Current Grades:

Reading _____

Math _____

Science _____

Social Studies _____

Classroom INSTRUCTION- Student has difficulty with:

A. _____ Becoming Interested

G. _____ Paying Attention: Print

M. _____ Expressing in Writing

B. _____ Getting Started

H. _____ Understanding Print

N. _____ Remembering

C. _____ Paying Attention

I. _____ Staying on Task

O. _____ Working in Groups

D. _____ Following Directions

J. _____ Completing Tasks on Time

P. _____ Homework

E. _____ Organization

K. _____ Working Independently

Q. _____ Test Grades

F. _____ Reading Textbooks

L. _____ Expressing Verbally

R. _____ Other _____

Tier 1 Academic Interventions Implemented in Classroom:

Other Pertinent Information:

BEHAVIOR- Student has difficulty with:

A. _____ Self-concept

G. _____ Depressed/ Sadness

M. _____ Apathetic Learner

B. _____ Fighting

H. _____ Withdrawn

N. _____ Disrespectful to Students

C. _____ Hyperactive

I. _____ Shyness

O. _____ Disrespectful to Teacher

D. _____ Worried/ Anxious

J. _____ Making Friends

P. _____ Other _____

E. _____ Bullying

K. _____ Peer Pressure

F. _____ Always Tired

L. _____ Aggressive/ Confrontational

Tier 1 Behavioral Interventions Implemented in Classroom:

Other Pertinent Information:

***Please attach DATA and DOCUMENTATION to this document (iReady, Study Island, etc...)**

MADISON COUNTY SCHOOL DISTRICT

SCHOOL INTERVENTION TEAM MEETING INVITATION

To the Parent/Guardian of:

Grade:

School Name:

Date Sent:

The School Intervention Team (SIT) is a committee of educators at our school that meets to assist teachers in finding new or different methods to help students improve performance in the school setting. Your child has been referred to the School Intervention Team for assistance and recommendations.

The purpose of SIT meetings is to discuss all of the elements of schooling that may affect a child's achievement. The meeting also provides the classroom teacher and other school personnel with an opportunity to discuss the strategies that they have been using in the classroom and possibly other settings. The SIT may identify additional interventions to improve your child's performance. You are invited to attend these meetings so that you may express any concerns or questions you have regarding this process.

In any situation, should you be unable to attend the scheduled SIT meeting, your child's teacher or another member of the SIT will contact you regarding the outcome. If you have any questions or need additional information please do not hesitate to call us.

The meeting has been scheduled as follows:

Date:

Time:

Location:

Contact Person:

Phone:

PLEASE COMPLETE AND RETURN THE SECTION BELOW.

CHECK THE APPROPRIATE RESPONSE, SIGN BELOW AND RETURN TO YOUR CHILD'S TEACHER PRIOR TO THE SCHEDULED MEETING.

_____ Yes, I **will** attend the scheduled meeting.

_____ I am **unable** to attend the meeting. Please contact me at _____ to discuss the results.

Student Name: _____

Date: _____

Time: _____

Parent / Guardian Signature

Date: _____

**MADISON COUNTY SCHOOL DISTRICT
INTERVENTION PLAN-Integrity Monitoring**

RTI -2

Development Date: _____ Tier: _____ Attendance _____ Academic _____ Behavior _____

STUDENT NAME _____ DOB _____ GRADE _____ SCHOOL NAME _____

Baseline data of target skill/behavior:	
Short-term Goal (next 4-6 weeks):	
Long Term Goal:	

INTERVENTION DESIGN (describe specific activities implemented):

Instruction - Intervention	Implementer	Duration/Frequency	Growth/Support
What instruction/behavior strategies will you use to increase the desired academic skill/behavior? Where: In what setting will the intervention be implemented?	Who is responsible for implementing this intervention plan? Who is the backup?	When: At what time, how long, & how often will the intervention be implemented?	Growth Monitoring Method (Describe type of monitoring tool, how often it will occur, charting system, etc., to be used.
	<input type="checkbox"/> GenEd Teacher <input type="checkbox"/> Sup.Facilitator <input type="checkbox"/> Counselor <input type="checkbox"/> Interventionist <input type="checkbox"/> Other _____	Time: _____ Frequency per week: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Duration in minutes: <input type="checkbox"/> 15 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 45 <input type="checkbox"/> 60	Skill Tested : _____ _____ _____ Tool Used: _____ _____
	<input type="checkbox"/> GenEd Teacher <input type="checkbox"/> Sup.Facilitator <input type="checkbox"/> Counselor <input type="checkbox"/> Interventionist <input type="checkbox"/> Other _____	Time: _____ Frequency per week: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Duration in minutes: <input type="checkbox"/> 15 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 45 <input type="checkbox"/> 60	Skill Tested : _____ _____ _____ Tool Used: _____ _____
	<input type="checkbox"/> GenEd Teacher <input type="checkbox"/> Sup.Facilitator <input type="checkbox"/> Counselor <input type="checkbox"/> Interventionist <input type="checkbox"/> Other _____	Time: _____ Frequency per week: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Duration in minutes: <input type="checkbox"/> 15 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 45 <input type="checkbox"/> 60	Skill Tested : _____ _____ _____ Tool Used: _____ _____

Level of Intervention: Tier 1 _____ Tier 2 _____ Tier 3 _____
Attendance _____ Academic _____ Behavior _____

Team Member Signature		Team Member Signature	
Parent:		MTSS/Rtl:	
Parent:		ESE Dept.	
Admin:		Other:	
Teacher:		Other:	
Teacher:			
Instructional Coach:			
Guidance Counselor:			

MADISON COUNTY STUDENT RECORD REVIEW

RTI - 4

Student's Legal Name _____ Student Number _____
Last First Middle

DOB _____ Race _____ Gender _____ School _____ Grade _____ Teacher _____

Parent/Guardian:

Mother _____ Father _____

Address _____
Street Address City, State, Zip

Home Phone _____ Mother's Work _____ Father's Work _____

Mother's Cell _____ Father's Cell _____

Does the student / family speak a language other than English? NO YES , what language _____	
Current Grades: (attach Report Card or Transcript) _____	
Standardized Tests: (attach FCAT/Progress Monitoring Scores) _____	
Does the student have a 504 plan? NO YES , Date: _____	
Has the student repeated a grade? NO YES , what grade(s): _____	
Attendance: Number of current year absences: _____	Number of prior year absences: _____
Number of current year tardies: _____	Number of prior year tardies: _____
Discipline Record (Number of Referrals) Current year: _____	Prior year: _____
Brought to SIT before? NO YES , date: _____	Outcome: _____
Prior psycho educational evaluation(s)? NO YES , Date: _____	
Known medical concerns or issues? NO YES : Describe: _____	
Student taking medication? NO YES : (List) _____	
Vision Screening? NO YES , Date: _____	Pass / Fail _____
Wears glasses / contacts? NO YES _____	
Hearing Screening? NO YES , Date: _____	Pass / Fail _____
Does student have Hearing Aid / Cochlear Implant? NO YES _____	
Speech / Language Screening? NO YES , Date: _____	Pass / Fail _____
Developmental Social History? NO YES _____	
Prior / Current ESE placement? NO YES , Program(s) _____ When? _____	
Assistive Technology? NO YES , Describe: _____	

 Signature of Person Completing Form

 Date

Intervention Calendar										Intervention Start Date:	
Name:						Reading Science		Math Social Studies			
Implemented by:						Behavior					
Intervention used:		Targeted Skill/Standard:				Phonological Awareness		Number and Operations			
Frequency:						Phonics		Algebra & Algebraic Thinking			
Duration:						High Frequency Words		Measurement and Data			
Time:						Vocabulary		Geometry			
		Comp. Literature									
		Comp. Info Text									
Monday		Tuesday		Wednesday		Thursday		Friday		Notes/GM Used	
Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:		
Performance:		Performance:		Performance:		Performance:		Performance:			
Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date of GM:	Peer Average:
Performance:		Performance:		Performance:		Performance:		Performance:			
Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date of GM:	Peer Average:
Performance:		Performance:		Performance:		Performance:		Performance:			
Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date of GM:	Peer Average:
Performance:		Performance:		Performance:		Performance:		Performance:			
Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date of GM:	Peer Average:
Performance:		Performance:		Performance:		Performance:		Performance:			
Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date of GM:	Peer Average:
Performance:		Performance:		Performance:		Performance:		Performance:			
Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date of GM:	Peer Average:
Performance:		Performance:		Performance:		Performance:		Performance:			

Administrator signature: _____

Fidelity Intervention Observation

Observer: _____ Interventionist: _____ School: _____ Grade: _____

Start Time: _____ End Time: _____ Skill: _____ Standard(s): _____

Criteria				
Focus	3	2	1	0
Structure and Delivery of Intervention	Adherence to precision to fully implement procedures as prescribed. All components are used to deliver a high intensity intervention. Correct time schedule is followed to provide optimal intervention during the time allocated. Intervention is delivered as designed.	Interventionist and students are engaged. Pace is effective and students are actively involved. Correct materials are used. Intervention time is focused and uninterrupted. Lesson is delivered as designed.	Interventionist and students are in correct places but materials are not at hand. Interventionist appears unprepared. Time delay to effectively begin intervention time. Some interruptions noted. No clear plan for the lesson.	Intervention not occurring at scheduled time and no manual or lesson plans used
SCORE: _____				
Management	Enthusiastic delivery by interventionist. Correct and effective management in place. Interventionist and students effectively making use of time. Structure of intervention provides effective pacing and optimal use materials.	Good delivery by interventionist. Management is effective. A few difficulties noted during implementation. Most students engaged in learning. Structure guides intervention time with occasional lapses in time.	Poor delivery by interventionist. The interventionist does not follow set procedures for effective implementation. Several students off task. Structure lacks coherence.	Ineffective delivery by interventionist. Students are not engaged. Interventionist does not guide structure for intervention.
SCORE: _____				
Progress Monitoring, Documentation, and Communication	Progress monitoring is completed once every other week and clearly documented on all forms. Communication of assessment results with teachers and parents exceeds the minimum requirements. Documentation of interventions and progress is very clear to understand and well organized and systematically communicated.	Progress monitoring is generally accurate. Communication with teacher and parents happens at least twice each nine weeks. Documentation of interventions and student progress is adequately communicated.	Progress monitoring is sporadic. There is not a clear system for communicating results with the teacher or parents. Limited documentation of interventions or progress is noted. Progress is rarely communicated.	Progress monitoring is not occurring. No communication with teachers or parents. No documentation of interventions or progress.
SCORE: _____				

Notes/Strengths/Concerns:

Results Checklist		YES	NO
Post observation review of fidelity check			
Review of areas of concern addressed, if any were indicated			
Plans for improvement established in areas identified			

I certify that everything reported on this form is accurate and correct and that interventions are being implemented with integrity at least 80% of the time.

Observer Signature/Title: _____

Fidelity Observation Checklist

Observer: _____ Interventionist: _____
 School: _____ Grade: _____
 Standard(s): _____

The Tier _____ Intervention is:

Description	Yes	No
Provided by or supervised by a highly qualified teacher with training in area of intervention		
Targeting one specific area of need/deficit/skill		
Targeting as a skill that was identified as an area of need by an assessment		
Occurring in addition to Tier I instruction		
Delivered in a small-group format		
Delivered with fidelity		
Delivered with evidence-based materials		
Provided the appropriate amount of time daily		
Provided the appropriate amount of time weekly		
Progress monitored at least every other week		

Team Recommendations (based on above criteria) :

Continue Current Interventions: _____ Tier 1 _____ Tier 2 _____ Tier 3	Yes ()	No ()
Implement Additional Interventions within: _____ Tier 1 _____ Tier 2 _____ Tier 3	()	()
Increase Level of Intervention (Tier): _____ Tier 1 _____ Tier 2 _____ Tier 3	()	()
Refer for further Evaluation:	()	()

I certify that everything reported on this form is accurate and correct and that interventions are being implemented with integrity at least 80% of the time.

Observer's Signature and Title: _____

Functional Behavioral Assessment Form

*requires parent consent

Student Name: _____ Date of Birth: _____ Grade: _____

Teacher: _____ School: _____

WHEN does the behavior occur the most? (Time?)

- ☐ Morning
- ☐ Afternoon
- ☐ Before/after school
- ☐ lunch/recess

OTHER EVENTS OF CONDITIONS occurring right before this behavior:

- ☐ teacher request
- ☐ a consequence has been imposed
- ☐ unexpected schedule change
- ☐ other

WHERE does the behavior occur the most?

- ☐ regular classroom
- ☐ cafeteria
- ☐ hallways
- ☐ other _____

WHO is present when the problem behavior is most likely to occur:

- ☐ teacher
- ☐ peers
- ☐ paraprofessional/TA
- ☐ other

HOW OFTEN does the behavior typically occur?

- ☐ times per day _____
- ☐ times per week _____
- ☐ random _____
- ☐ other _____

Motivation Assessment Scale

Direction: Read each question carefully and circle the **ONE** number that best describes your observations:

	Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
1. Would the behavior occur continuously, over and over if this student were left alone for long periods of time?	0	1	2	3	4	5	6
2. Does the behavior occur following a request to perform a difficult task?	0	1	2	3	4	5	6
3. Does the behavior seem to occur in response to your talking to other students in the room?	0	1	2	3	4	5	6
4. Does the behavior ever occur to get a toy, food or activity that this student has been told he/she can't have?	0	1	2	3	4	5	6
5. Would the behavior occur repeatedly, in the same way, for long periods of time, if no one were around?	0	1	2	3	4	5	6
6. Does the behavior occur when any request is made of the student?	0	1	2	3	4	5	6
7. Does the behavior occur whenever you stop attending to the student?	0	1	2	3	4	5	6
8. Does the behavior occur when you take away a favorite toy, food or activity?	0	1	2	3	4	5	6
9. Does it appear that this student enjoys performing the behavior?	0	1	2	3	4	5	6
10. Does this student seem to do the behavior to upset or annoy you when you are trying to get him/her to do what you ask?	0	1	2	3	4	5	6
11. Does this student seem to do the behavior to upset or annoy you when you are not paying attention to him/her?	0	1	2	3	4	5	6
12. Does the behavior stop occurring shortly after you give this student the toy, food, or activity he/she requested?	0	1	2	3	4	5	6

POSITIVE BEHAVIORAL INTERVENTION PLAN

Student Name: _____ Date of Birth: _____

Teacher: _____ Date Plan Begins: _____

Student Reinforcers:**Target Behavior:****Antecedents to Behavior:****Specific Interventions to Change Behavior:**

-
-
-
-

Persons and Timelines for Interventions:

- Position Responsible _____ Begin Date: _____
- Position Responsible _____ Begin Date: _____
- Position Responsible _____ Begin Date: _____
- Position Responsible _____ Begin Date: _____

REPLACEMENT BEHAVIOR

When and how student will be taught and practice replacement behavior:

Plan for reinforcing replacement behavior:

Describe the plan for dealing with the student at the first sign of target behavior:

Student Observation Form

***requires parent consent**

Student: _____ Grade: _____ Date: _____
Subject/Period: _____ Is Lesson On Grade Level: _____
Teacher: _____ Time: _____

Guiding Questions for Narrative:

1. During the observation, what was the student's response to the classroom activity? Level of participation?
2. How was the student's behavior similar to the other students in the classroom? How was the behavior different?
3. According to his/her classroom teacher, is the behavior being observed, consistent with the student's daily performance? If not, how was it different?

Observation Narrative:

[illegible]

Behaviors Noted During Observation:

- | | |
|--|---|
| <input type="checkbox"/> Reverses or confuses letters, words or numbers | <input type="checkbox"/> Appears to be frustrated |
| <input type="checkbox"/> Poor understanding of Math Skill (Number Sense, etc.) | <input type="checkbox"/> Easily distracted |
| <input type="checkbox"/> List Skills _____ | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> Poor understanding of Vocabulary | <input type="checkbox"/> Remains on-task |
| <input type="checkbox"/> Loses place when reading | <input type="checkbox"/> Refuses to complete assignments |
| <input type="checkbox"/> Misinterprets verbal questions and directions | <input type="checkbox"/> Talks out |
| <input type="checkbox"/> Difficulty following directions in sequence | <input type="checkbox"/> Out of Seat |
| <input type="checkbox"/> Difficulty expressing ideas | <input type="checkbox"/> Slow to react and follow directions |
| <input type="checkbox"/> Works well independently | <input type="checkbox"/> Withdrawn |
| | <input type="checkbox"/> Relates well with adults |
| <input type="checkbox"/> Poor gross motor control | <input type="checkbox"/> Relates well to peers |
| <input type="checkbox"/> Poor fine motor control | <input type="checkbox"/> Appears Inattentive |
| | <input type="checkbox"/> Engages in destructive and/or aggressive behavior |
| | <input type="checkbox"/> Uses poor judgment in social and interpersonal relations |
| | <input type="checkbox"/> Makes inappropriate responses to conversations and questions |

Observer's Signature

Observer's Title

Length of Observation

District School Board of Madison County

210 NE Duval Avenue-Madison, Florida 32340

Parent Consent for Screening

Student Name	Grade	DOB	Homeroom Teacher	School Name

Dear Parent/Guardian,

We are interested in your child's success in school. Therefore, your child has been referred to the School Intervention Team to address his/her school performance. The team would like to gather more information by administering individual screenings and conduction observations.

In order for this to be accomplished, your consent for screening must be obtained. All information gathered will assist in educational planning and will be shared with you.

If you have any questions, please contact: _____

Screenings/Observations Requested:

- ☐ Vision and Hearing
- ☐ Speech
- ☐ Language
- ☐ Behavior
- ☐ Cognitive
- ☐ Academic

Please indicate your decision below:

- ☐ Yes, I give consent for my child to have individual screening/observation
- ☐ No, I do not give consent at this time

Parent Signature: _____ Date: _____

OFFICIAL USE ONLY BELOW THIS LINE

	Department	Date	Pass/Fail	Recommend Re-Screen Y/N	Evaluator Name
	Clinic				
	Speech				
	Language				
	Behavior				
	Cognitive				
	Academic				

Return this form to: _____