Sacramento City Unified School District

School Name

**Student Study Team Meeting Summary**

Check one:  Initial SST  2nd (Follow-up) SST  3rd (Follow-up) SST

1. **Student Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Today’s Date** | **Student Name** | | | **Grade** | **Teacher** | | | **Age** | | **Birthdate** | | **Gender** | |
|  |  | | |  |  | | |  | |  | |  | |
| Primary Language: |  | | | | Previous SST Date(s): | | |  | | | | | |
| Programs: | Foster Youth | Homeless | ELL | | | Speech | SSC | | SpEd | | 504 | | Other: |

1. **Strengths:** Include strengths at school (academic, social, interests) and at home (family supports, community, and interests):

Type student strengths here

1. **Areas of Concern:** Include academic, emotional, health, social and home concerns

Type student concerns here

1. **Student History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Health** | | **Assessment Data (Most Current)** | |
| Was Pregnancy & birth typical: Yes No | If Complications, please describe: | SBAC – ELA: |  |
|  | | SBAC – Math: |  |
| Developmental milestones met:  Walking  Talking  Toileting | | BMK – ELA: |  |
| Health concerns:  Hearing  Vision  Dental  Sleep | | BMK – Math: |  |
| Chronic conditions: | Current medications: | Reading: |  |
| Does student have health insurance? Yes No | Type of insurance: | Writing: |  |
| **Family & Home** | | Math: |  |
| Family members (in or out of the home): |  | CELDT: |  |
| History of schools attended (include preschool): | | # of Absences: |  |
| English Language Learner? Yes No | | # of Tardies |  |
| Other: | | Behavior: |  |

1. **Prior Interventions**

|  |  |  |  |
| --- | --- | --- | --- |
| **Intervention** | **Time Frame** | **Goal** | **Outcome** |
|  | From       to |  |  |
|  | From       to |  |  |
|  | From       to |  |  |
|  | From       to |  |  |
|  | From       to |  |  |

1. **Action Plan**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Intervention/Accommodation** | **Start Date** | **Person Responsible** | **Expected Outcome** | **Review Date** | **New Action?** |
|  |  |  |  |  | Yes  No |
|  |  |  |  |  | Yes  No |
|  |  |  |  |  | Yes  No |
|  |  |  |  |  | Yes  No |
|  |  |  |  |  | Yes  No |

1. **Follow-up Date** (schedule within 4-8 weeks):
2. **Team Members**

|  |  |  |
| --- | --- | --- |
| **Title** | **Name** | **Signature** |
| 1. Parent/Guardian |  |  |
| 1. Student (if applicable) |  |  |
| 1. Administrator |  |  |
| 1. Referring Teacher |  |  |
| 1. Facilitator |  |  |
|  |  |  |
|  |  |  |
|  |  |  |