

General Education Intervention

What is general education intervention (GEI)?

From 511 IAC 7-17-40

“General education intervention” means a written formal system, at the building level, of methods and procedures used with a student to address those aspects of a student’s classroom performance that are substantially affecting educational outcomes. General education intervention shall not be a prerequisite to an educational evaluation

Basically, GEI is a process. It is a process used to ensure that each student has the supports needed to be successful in meeting the Indiana Academic Standards for student learning. Although GEI is not a prerequisite to referral for an educational evaluation, every student is entitled to a free appropriate public education in the least restrictive environment. Participation in the GEI process is the first step for professionals to ensure such for every student who is experiencing learning difficulties.

In Section 2 of this manual there is information and forms on developing and implementing a GEI team. Also, the pages that follow is an example of how several of the forms could be used during a GEI team meeting.

For example:

- **GEI Form 3: Request for GEI Team Meeting** page is to request a GEI team meeting
- **GEI Form 4: GEI Meeting Notes** page can assist in maintaining a log of discussion during the GEI meeting
- **GEI Form 2: Documentation of Classroom Interventions** can be completed by the general education teacher of strategies that have been implemented and the results of those strategies
- **GEI Form 5: GEI Intervention Action Plan** page can be completed by all members of the GEI team at the meeting to develop an action plan

GEI Form 3: Request for GEI Team Meeting

Date: _____
Student: _____ DOB _____ Grade Level: _____

School: _____

Name(s) and title(s) of individual(s) requesting GEI Team meeting:

I/We have a student who is experiencing difficulty in the area(s) of
_____ Academic performance _____ Physical/Neurological
_____ Behavioral/Emotional constraints
adjustment _____ Other: (*specify*): _____

Academic Data: List (attach) subject and current grades earned or attach photocopy of report card with concerns highlighted and notation here; attach relevant work samples and **GEI Form 2: Documentation of Classroom Interventions**

Behavioral Data: Briefly note concern and attach copies of behavioral documentation forms and **GEI form 2: Documentation of Classroom Interventions**

Physical Data: Briefly note concern and attach **GEI Form 2: Documentation of Classroom Interventions** and any other relevant documentation.

Other concern: Briefly note concern and attach **GEI Form 2: Documentation of Classroom Interventions** and any other relevant documentation.

In addition to the GEI Team, I/we would like the following person(s) invited to the meeting:

Received by _____ on _____
GEI Team Chairperson Date

GEI Form 2: Documentation of Classroom Interventions

Student: _____ Grade Level: _____ Academic Year: _____

Academic or behavioral concern substantially affecting student outcomes: _____

Intervention	Duration of intervention	Consistency of application	Results of this intervention
			Student response: Teacher response:
			Student response: Teacher response:

GEI Form 5: GEI Intervention Action Plan

Date: _____

Student: _____ DOB: _____ Grade level: _____ School: _____

Student goal: _____

Intervention strategy(ies)	Implementation process: Who, when, how	Progress monitoring: (a) How goal is to be assessed (b) What constitutes success (benchmarks and total success) (c) Who will assess (d) Dates of monitoring

Action Plan review date and time: _____

Student: _____

Intervention strategy(ies)	Implementation process: Who, when, how	Progress monitoring: (a) How goal is to be assessed (b) What constitutes success (benchmarks and total success) (c) Who will assess (d) Dates of monitoring

Referral for Evaluation Check List

Student: _____ School: _____

1. Initial referral received in special education office: _____

Signed by parent/guardian: _____

60 day timeline: _____

2. Information needed:

_____ **Referral form** with permission for evaluation, signed and dated

_____ **Classroom teacher observation reports**

_____ **Records review** (i.e., copy of testing stickers from accum folder, attendance record, disciplinary records, health record)

_____ **Social and developmental history**

_____ **GEI Team reports** (see Tier 2)

_____ **Intervention plan**, follow-up report as available (see Tier 2)

_____ **Vision screening** (see Tier 2)

_____ **Hearing screening** (see Tier 2)

_____ **CODA Sheet**

3. Referral returned to sending school for information as indicated above: _____

4. Completed referral received in VSEC office: _____

Date of report: _____
Date received by VSEC: _____

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CODA Information Form

(Attach to front of IEP)

Initial Annual Case Review Triennial Transfer
 Related Service Withdrawal Other: _____

Student name: _____

STN#: _____ DOB: _____ Grade: _____

Charter School attending: _____

Parent/Guardian: _____

Address: _____

Telephone: _____

Primary Exceptionality area: _____ Did not qualify for Special Education _____

Teacher of Record: _____ 3 year re-evaluation date: _____

If Emotional Disability

Full Time: (05) _____ All Others: (06) _____

Secondary Exceptionality area(s): _____ Teacher of Record: _____

_____ Teacher of Record: _____

Triennial permission attached: Yes No

Related services

Interpreter (Hearing Impaired)

Adaptive P.E.

Audiological services

Occupational therapy

Physical therapy

Assistive technology

Other (*specify*) _____

State Wide Testing

Regular Regular with accommodations Alternate assessment (ISTAR)

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Referral for Educational Evaluation

A referral for a multi-disciplinary evaluation has been made for _____
(name of student) to determine possible eligibility for special education services to address
remediation strategies.

STN# _____ General Education Teacher: _____

Date received in the VSEC office: _____

60 day Compliance date: _____

A. Reason for referral (attach GEI/RtI Documentation/ISTAR Alternate Assessment):

- | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> 1. Academic concerns
<input type="checkbox"/> 2. Social/emotional concerns
<input type="checkbox"/> 3. Physical concern
<input type="checkbox"/> Other (<i>specify</i>): _____ | <input type="checkbox"/> 4. Previous special education services
<input type="checkbox"/> _____ |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|

B. Educational history (attach class schedule, progress reports, transcript, and standardized test results):

- | | | | | |
|--------------------------------|--------------|------------|-------------|------------|
| _____ Retention | Y () | N () | Grade _____ | Year _____ |
| _____ Psychological evaluation | Y () | N () | Year _____ | _____ |
| _____ Tutoring: | _____ School | _____ Home | | |
| _____ Speech/Language therapy | Grade(s) | _____ | | |
| _____ Occupational therapy | Grade(s) | _____ | | |
| _____ Physical therapy | Grade(s) | _____ | | |
| _____ Number of school changes | _____ | | | |

C. Areas to be addressed in evaluation:

- | | |
|---------------------------------------------|-------------------------------------------|
| _____ Eligibility for special education | _____ Suggestions for academic strategies |
| _____ Academic strengths and weaknesses | _____ Suggestions for behavior strategies |
| _____ Other areas (<i>specify</i>): _____ | |

D. School interventions already tried to help student (attach GEI documentation/RtI):

- | | |
|------------------------------|---------------------------------------|
| _____ Student conference | _____ Consult school psychologist |
| _____ Parent conference | _____ Adjusted workload |
| _____ Principal conference | _____ Modified materials/presentation |
| _____ Tutor/Remedial service | _____ Changed group or seating |

- | | |
|-------------------------------|--------------------------------|
| _____ Consult past teachers | _____ Study partner/peer tutor |
| _____ Behavior management | _____ Cooperative learning |
| _____ Isolation/Time away/out | _____ Other _____ |

Results of the above interventions: _____

E. Communication disorders (for speech/language referrals): Attach Communicative Disorders Educational Summary form.

F. Specific questions to be considered through evaluation: _____

G. Parent concerns: _____

Signature of referring person

Date

Signature of principal/school leader

Date

Consent for Initial or Additional Evaluation

Student:
Teacher of Record:

Evaluation Date:
Projected Re-Eval date:
Conference date:
File Date:

Assessment Procedures

The areas assessed in this evaluation may include intelligence, achievement, social/emotional adjustment, perceptual abilities, motor abilities, and communication skills. Techniques employed in the evaluation may include classroom observation, individual tests, group tests, interviews, teacher rating scales, and review of records.

Assessments Requested:

Additional Notes:

Authorization by Parent/Guardian

I, the parent or legal guardian of the above named student, do understand the reason for this request for multidisciplinary evaluation and have received an explanation regarding the evaluation procedures which may be utilized. I understand the evaluation will be conducted by a multidisciplinary evaluation team including the school psychologist, teacher(s), and other specialists. I am aware that I will be invited to a case conference within sixty (60) school days to receive an explanation of the test results. I understand the Case Conference Committee will utilize the results and other pertinent information to make educational program recommendations for my student. I have received a copy of the "Notice of Parents' Rights", and the Special Education Department "Parent Handbook."

I understand that I have the right to obtain a copy of the results of the evaluation and/or request a meeting with an individual who can explain the results of the evaluation at the school my child attends during the five (5) instructional days prior to the Case Conference Committee meeting.

I request

- A meeting with someone to discuss the test results prior to the date of the Case Conference meeting.
- A copy of the test results and wish to discuss these with someone over the telephone prior to the Case Conference meeting.
- A copy of the test results prior to the Case Conference meeting and/or
- A copy of the test results at the Case Conference meeting.

I give my permission for this evaluation.

Signature of Parent

Date

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Social and Developmental History Intake Questionnaire

Family Data:

Child's name _____ Age _____ Gender _____ DOB _____

Address _____ Phone _____

School _____ Grade _____ Teacher _____

Mother's name _____ Education _____ Occupation _____

Address _____ Phone _____

Father's name _____ Education _____ Occupation _____

Address _____ Phone _____

Stepparent's name _____ Education _____ Occupation _____

Address _____ Phone _____

Marital status of parents: married _____ divorced _____ separated _____ other _____

If parents are separated or divorced, date/age this occurred: _____

Legal status (circle one): 01 Biological 02 Maternal 03 Paternal 04 Ward of Court

05 Ward of DMH 06 Ward of DPW 07 Nursing Home 08 Foster

09 Other _____

Ethnic background (circle one): A-American Indian B-Asian or Pacific Islander

C-Hispanic D-Black American E-Caucasian F-Multi-racial

Who has legal custody of child? Mother _____ Father _____ Joint _____

Other _____

With whom does the child mostly live? _____

Have parental rights of either parent been terminated? Yes _____ No _____

If yes, which parent? _____

If separated/divorced, how often does child see other parent?

Regular, weekly contacts _____ Infrequent contact _____ No contact _____

List of siblings (not all may be in home) and others living in household:

Name	Gender	Relationship to child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Medical History

Please check any illnesses that have occurred in the immediate family.

<u>Condition</u>	<u>Family Member</u>	<u>Condition</u>	<u>Family Member</u>
<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> A.D.D.	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Suicide Attempt	_____	<input type="checkbox"/> Other	_____

Is there a history of learning (reading/spelling/math) problems within the family?

Yes No If yes, explain: _____

Are there psychiatric/psychological problems in the family? Yes No

If yes, explain: _____

Developmental History

Mother's age at time of pregnancy: _____ Under doctor's care? Yes No

Length of pregnancy: _____ 9 months _____ Premature _____ Weeks early

_____ Past due date _____ Days/weeks late

Birth weight: _____

Were there any complications during this pregnancy:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Measles	<input type="checkbox"/> Threatened miscarriage
<input type="checkbox"/> Toxemia	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Bed rest required
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Abnormal weight gain/loss	<input type="checkbox"/> Unusual stress
<input type="checkbox"/> Premature labor	<input type="checkbox"/> Other	_____

During pregnancy did mother:

<input type="checkbox"/> Smoke	<input type="checkbox"/> Use alcohol
<input type="checkbox"/> Take a prescribed medication (Name _____)	<input type="checkbox"/> Use nonprescription drugs (Name _____)

Length of labor _____

Were there any complications during labor: _____ Use of forceps

Breech Umbilical cord distress

Caesarean section Labor induced

Other _____

Any complications at delivery: _____ Jaundiced _____ Respiratory problems

Oxygen required _____ Incubator: How long? _____

APGAR Score (if known) _____ "Blue" baby

Other _____

Birth Information:

Was born with no apparent complications

Weighed less than 5½ pounds at birth

Spent time in a neonatal intensive care unit Was born post-maturely

_____ Required assistance with breathing _____ Was born prematurely
 Other birth information: _____

Milestones: (list approximate age of child if possible)

Speech and language (talking)	Average	Fast	Poor
Motor development (sitting, crawling, walking)	Average	Fast	Poor
Self-help skills (dressing, feeding, toileting)	Average	Fast	Poor

Were there any skills that you or your doctor felt were slower than expected? _____

As an infant:

Were there any feeding problems? ___ Yes ___ No
 Were there any sleeping problems? ___ Yes ___ No
 Was the child unusually _____ quiet or _____ unusually active?
 Was it easy to establish a routine with the child? ___ Yes ___ No
 Did the child like being held? ___ Yes ___ No

Medical History:

Hearing:

Ear infections: _____ Yes _____ No If yes, how often? _____
 Have tubes been inserted? Right ear _____ Left ear _____ Both _____
 Age (most recent) _____ If more than once, previous ages: _____
 Are tubes still present? _____ Yes _____ No Which ear(s) _____
 Last known ear infection: _____
 Know hearing loss? _____ Yes _____ No If yes, type? _____
 Other hearing/ear problems? _____

Vision

Passed most recent school screening? _____ Yes _____ No Date _____
 _____ Wears glasses _____ has glasses (not always worn)
 _____ Astigmatism _____ farsighted
 _____ Nearsighted _____ other _____
 _____ Colorblind

Childhood illnesses

Please check those which your child has had. Please give approximate age.

_____ Allergies (please list to what) _____
 _____ Adenoids _____ Asthma _____ Tonsillitis
 _____ ADHD/ADD _____ Seizures _____ Urinary infections
 _____ Rheumatic fever _____ Measles _____ Sinus Condition
 _____ Chicken pox _____ Head injury _____ Scarlet fever
 _____ Convulsions _____ Pneumonia _____ Mumps
 _____ Bronchitis _____ Meningitis _____ Frequent colds/coughs

Other: _____

Is your child on any long term medications? (Over 80 days?)

Name	Dosage	Condition
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has child ever been hospitalized? _____ yes _____ no

Age	Length of Stay	Condition
_____	_____	_____
_____	_____	_____

Has child ever had surgery(ies)? _____ yes _____ no

Age	Location	Condition	Length Hospitalized
_____	_____	_____	_____
_____	_____	_____	_____

Has child ever had a loss of consciousness? _____ yes _____ no

Age	Cause	Length
_____	_____	_____
_____	_____	_____

Have you been told your child shows any of the following at school?

_____ Does not listen to directions	_____ Poor handwriting
_____ Is disorganized	_____ Does not complete class work
_____ Daydreams	_____ Makes careless errors
_____ Is easily distracted	

What concerns do you have about school? _____

Social History

Friendships

Makes friends easily	___ yes	___ no
Keeps friendships	___ yes	___ no
Prefers playing with younger children	___ yes	___ no
Prefers the company of adults to peers	___ yes	___ no
Prefers to play alone	___ yes	___ no
Is not socially accepted by classmates	___ yes	___ no

Are there children within your neighborhood with whom your child can play?

_____ yes _____ no

Does your child have any difficulties interacting within a small group of children?
 _____ yes _____ no If yes, please explain _____

Does your child participate in any of the following youth activities?

<input type="checkbox"/> Boys/Girls Club	<input type="checkbox"/> Scouts
<input type="checkbox"/> YWCA/YMCA	<input type="checkbox"/> Big Brother/Big Sister program
<input type="checkbox"/> Church youth group	<input type="checkbox"/> T-Ball or other sports
<input type="checkbox"/> Other: _____	

What activities/sports/hobbies does your child most enjoy? _____

Temperament/Behavior

Check those which you feel describe your child:

<input type="checkbox"/> Has a short attention span	<input type="checkbox"/> Easily frustrated
<input type="checkbox"/> Has temper tantrums	<input type="checkbox"/> Gives up easily
<input type="checkbox"/> Is shy or timid	<input type="checkbox"/> Is impulsive
<input type="checkbox"/> Does not get along well with siblings	<input type="checkbox"/> Often seems sad or unhappy
<input type="checkbox"/> Overreacts when not getting own way	<input type="checkbox"/> Has fears
<input type="checkbox"/> Seems uncomfortable meeting new people	

Has your child been placed on house arrest? yes no
 If yes, when and for how long? _____
 For what reason? _____

Has your child ever been placed on probation? yes no
 If yes, please give probation officer and dates of probation: _____

Has your family ever had involvement with any of the following:
 Division of Family and Children Child Protective Services
 Social Services Other community agencies (*specify*) _____
 Date of involvement _____ Purpose: _____

Have there been any incidents involving abuse? yes no
 Physical Sexual Emotional/mental
 If so, please explain _____

Has your child experienced the loss of a significant person in his/her life through death, abandonment or incarceration? yes no
 If so, please explain _____

Has your child received counseling or therapy? yes no
 If yes, therapist's name _____ Agency _____
 Reason for therapy _____
 Is counseling ongoing? yes no

School History

Has your child been evaluated for SSI benefits? yes no
 If yes: Special speech/play groups Special Needs Preschool
 Early Head Start First Steps _____
(type of services)

Did child attend regular preschool/Head Start? yes no
 If yes, at what age _____ Location/Name of school: _____

During preschool, were any of the following reported?
 Often noncompliant Aggressive
 Acts without thinking Shy
 Into everything Starts but doesn't finish work
 Easy going Overly active
 No concerns reported

Did you have any concerns during this period? yes no

If your child has attended schools other than current one, please list.

Grade	School	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever been recommended for retention? yes no
 If yes, did you agree? yes no
 Has your child been retained? Yes no Grade(s) _____

Place a check for those educational problems you feel your child currently has:

<input type="checkbox"/> Reading	<input type="checkbox"/> Handwriting	<input type="checkbox"/> Social
<input type="checkbox"/> Oral reading	<input type="checkbox"/> Written expression	<input type="checkbox"/> Emotional
<input type="checkbox"/> Comprehension	<input type="checkbox"/> Arithmetic	<input type="checkbox"/> Motor development
<input type="checkbox"/> Spelling	<input type="checkbox"/> Behavior	<input type="checkbox"/> Speech
<input type="checkbox"/> Other (<i>specify</i>): _____		

Does your child bring assignments home? yes no
 Does your child complete assignment book? (middle school) yes no
 Has your child received speech therapy? yes no Grades _____
 Has your child received physical therapy? yes no Ages _____
 Has your child received occupational therapy? yes no Ages _____

Has your child received extra tutoring? _____ yes _____ no

When _____

With whom? _____

Do you feel your child likes school? _____ yes _____ no

If no, why do you think he/she does not? _____

Please note other concerns _____

When is the best time and place for the school psychologist to contact you? _____

Phone number: _____

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Multidisciplinary Team Report Classroom/Teacher Report

Student: _____ Date: _____

Teacher Checklist	Often	Some	Rarely	Never
1. Reads at or above current grade level				
2. Reverses letters while reading/writing				
3. Is able to spell at or above grade level				
4. Applies appropriate phonic skills to decode grade level vocabulary				
5. Is able to identify the main theme after reading a story at grade level				
6. Can correctly pronounce reading vocabulary selected from grade level text				
7. Has difficulty recalling pertinent facts of a story at grade level				
8. Writes legibly				
9. Has difficulty forming letters				
10. Takes unusually long periods of time to do written assignments				
11. Performs at or above grade level in math				
12. Has difficulty solving word problems at grade level				
13. Has difficulty solving computational problems at grade level				
14. Pays attention to class discussion/peer recitation				
15. Participates in class discussion				
16. Pays attention to teacher presentation				
17. Uses appropriate expressive vocabulary at grade level				
18. Disrupts class by talking out loud				
19. Completes work accurately				
20. Is easily frustrated with assignment				
21. Requires assistance to complete assignments				
22. Follows oral directions				
23. Obeys class rules				
24. Tends to daydream				
25. Requires constant reminders to perform tasks				
26. Requires frequent review to retain information				
27. Fluctuates in day to day academic performance				

28. Wastes time				
29. Is out of seat				

Student:: _____

Modality through which student learns best ___ auditory ___ visual ___ tactile

Modality through which the student expresses self: _____ verbal ___ written

___ Other (*explain*): _____

Comments: _____

Teacher: _____

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**Multidisciplinary Evaluation Team Member Report
Hearing Screening Report**

Student name: _____ School: _____

D.O.B.: _____ Gender: M ___ F ___ Grade: _____

A. Hearing Screening Report: (Please screen if last test is over one year old)

Date of Test: _____

Results: Right Pass _____ Fail _____

Left Pass _____ Fail _____

Could not be tested _____

Criteria Db (intensity level) _____ Hz (frequencies) _____

Comments:

B. Speech Language Report:

Is student enrolled in speech/language therapy program? Yes _____ No _____

C. Referral to family physician recommended: Yes _____ No _____

D. Additional Comments

Evaluator, title

Date

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Multidisciplinary Evaluation Team Member Report
Vision Screening Report

Student name: _____ School: _____

D.O.B.: _____ Gender: M ___ F ___ Grade: _____

A. Vision Test Results:

Date of Test: _____

Results: Right (OD) _____ Left (OS) _____ Both (OU) _____

Glasses Worn: Yes ___ No ___ Always ___ Sometimes ___

Distance Only _____ Reading Only _____

B. Additional Medical Information:

C. Referral to Optometrist / Opthamologist recommended:

_____ yes _____ no

D. Additional Comments:

Evaluator, title

Date