PRE-K STUDENT ASSISTANCE TEAM REPORT

Name:	**Date of Birth:**	**School:**
Parent/Guardian:	**Telephone #:**	**Teacher:**
Address:	**WVEIS #:**	**Grade:**
	Medicaid #:	**Current Date:**

Reason for Referral:

Child's Functional Abilities Within Developmental Areas:

- **Communication (Expressive and Receptive):**
- **Motor Development:**
- **Social/Emotional:**
- **Cognitive:**
- **Adaptive:**

Child's Name:	**Date of Birth:**	**Current Date:**

Additional Information/Concerns:	
Recommended Actions:	**Person/Team Responsible**

Parent/Guardian: _____ **School Administrator/Chairperson: _____**
SAT Coordinator: _____ **School Psychologist: _____**
General Education Teacher: _____ **Special Educator: _____**
School Counselor: _____ **School Nurse: _____**
WV BTT Representative(s):_____ **Early/Head Start FSS:_____**
_____ _____
_____ **Other(s):**_____
_____ _____
_____ _____