

Carbon County School District #2

Building Intervention Team Process

Date	BIT Process	Form
_____	1. Receive referral from teacher	Referral to BIT
_____	2. BIT meets, reviews data, plans interventions	BIT minutes, academic results, Intervention page
_____	3. Notify Parents of BIT meeting (Use school letterhead)	Parent notification letter
_____	4. Staff implements interventions and documents	Intervention page
_____	5. BIT meets to review interventions	BIT minutes
_____	6. BIT decides to continue with interventions, adjust or make referral to special education	Parent notification letter, referral to special education
_____	7. If BIT interventions continue, BIT folder stays at the school. If referral is made, entire BIT folder and signed referral is sent to Special Education Director. A parent interview should be conducted before the file is sent to Central Office to gain additional information in guiding the assessments.	

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Building Intervention Team Referral

Child's Name _____ Date of Birth _____

School _____ Grade _____ Teacher _____

Parent's Name _____

Address _____ Phone _____

Reasons for Referral:

*Attach record of interventions already attempted

Check when completed.

_____ The cumulative records have been reviewed. The following significant data was discovered. (Previous BIT referral, retention, excessive absences, etc.)

Teacher signature and date: _____

Deliver this form to the BIT Chairperson

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Minutes of Initial Building Intervention Team Meeting

Student Name _____ **Birthdate** _____ **Grade** _____

School _____

Minutes of meeting. Include a summary and recommendations in the minutes. Attach Review of Test Summary page and Intervention Documentation form.

The following members were part of the Building Intervention Team meeting. This team needs to include: two certified regular education teachers (one the classroom teacher), principal, and other knowledgeable staff members.

Member	Position	Date

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Building Intervention Team

Academic Report

Student Name _____ **Grade** _____ **Date** _____

Current Academic Performance:

Subject	%/Grade	Instructional Level
Language Arts		
Math		
Science		
Social Studies		

State Assessments	Score	Date
Reading		
Math		
Writing		
Science		

DIBELS	Score	Date
Fall		
Winter		
Spring		

MAP	Results	Date
Reading		
Math		
Language Arts		
Science		

District Writing	Rubric Rating	Date
Fall		
Spring		

Other Tests (Lexia-QRT, Star Reading, Star Math, Common content assessments)	Results	Date

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Building Intervention Team

Intervention Documentation Form

Student Name _____ Date of Birth _____

School _____ Grade _____

Skill Area: _____

Intervention: _____

Frequency (times per week) _____ Duration (amount of time) _____

Method of evaluation and how often _____

Results of evaluation (attach progress monitoring) _____

Teacher Signature _____

Skill Area: _____

Intervention: _____

Frequency (times per week) _____ Duration (amount of time) _____

Method of evaluation and how often _____

Results of evaluation (attach progress monitoring) _____

Teacher Signature _____

Skill Area: _____

Intervention: _____

Frequency (times per week) _____ Duration (amount of time) _____

Method of evaluation and how often _____

Results of evaluation (attach progress monitoring) _____

Teacher Signature _____

Carbon County School District #2

Referral – Special Education

Name of Student _____ **Grade** _____ **Date** _____

Parent of Guardian _____

Address _____

Phone Number _____

Reason for Referral: State reason(s) you believe that the child has a disability and needs special education and related services. Explain in detail the child’s academic and nonacademic performance. Include any important medical, emotional or other health related information.

Interventions and Effects: Discuss and detail interventions, services, or other programs used to address the child’s needs. Include information about the duration of the interventions, services or programs that were attempted and the effects of the interventions on the child’s performance, to the extent known.

Vision and Hearing Screening: Document the results of vision and hearing screening; any failed portion indicates a failed screening.

Vision Screening Date _____

Vision is: Corrected (glasses/contacts) Uncorrected

	Both	Left	Right
Distance Acuity	20/	20/	20/
Near Acuity	20/	20/	20/
Tracking		Pass Fail	
Stereo Vision		Pass Fail	
Color Vision		Pass Fail	
Notes:			

Hearing Screening Date _____

Otoscopy:			
Pure Tone Results @ 20 dB	1.0 kHz	2.0 kHz	4.0 kHz
Right Ear	Pass Fail	Pass Fail	Pass Fail
Left Ear	Pass Fail	Pass Fail	Pass Fail
Tympanometry	Pressure		Compliance
Right Ear	Pass Fail		Pass Fail
Left Ear	Pass Fail		Pass Fail
Notes:			

Parent Involvement: Indicate how the concerns have been addressed with parent(s).

Signature of person making the referral:

Date _____

Name of person receiving the referral: _____

Date of receipt: _____

Procedural safeguards provided to parent on _____ by _____