

**Capistrano Unified School District
San Juan Capistrano, California**

Student Study Team Documentation Form

Student's Name _____ School _____

Primary Language: Home _____ Student _____ English Proficiency _____

Initial Student Team Meeting Date _____

Concerns:

Intervention(s) Recommended:

Date of proposed review meeting of intervention effectiveness _____
(Allow six weeks for assessment of effectiveness)

_____ Signature	_____ Title	_____ Signature	_____ Title
_____ Signature	_____ Title	_____ Signature	_____ Title
_____ Signature	_____ Title	_____ Signature	_____ Title

Review Meeting Date _____

Summarized results of intervention(s).

Plan for intervention modification(s).

Refer for Special Education Assessment yes No
if referred, reason for referral:

_____ Signature	_____ Title	_____ Signature	_____ Title
_____ Signature	_____ Title	_____ Signature	_____ Title
_____ Signature	_____ Title	_____ Signature	_____ Title