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| **Time** | **Student Name/DOB** | **Teacher** | **Student #** | **Disabilities/Medical** | **Vision/****Hearing** | **Purpose of the Meeting** |
| **Grade** | **Documentation Needed** |
| 9:00am-9:45am |  |  |  |  |  | Initial |
|  | (Counselor Referral) |
| 9:45am-10:30am |  |  |  |  |  | Initial |
|  | (Parent Request) |
| 10:30am-11:15am |  |  |  |  |  | Eligibility |
|  |  |
| 11:15am-12:00pm |  |  |  |  |  | Initial |
|  | (Counselor Referral) |
| 12:45pm-1:45pm |  |  |  |  |  | Eligibility |
|  |  |
| 1:45pm-2:30pm |  |  |  |  |  | Initial |
|  | (Parent Request) |
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