STUDENT SERVICES SUMMARY FORM

STUDENT INFORMATION

LEGAL FAMILY NAME	LEGAL FIRST NAME	LEGAL MIDDLE NAME(S)
GENDER:	BIRTH DATE (YYYY MM DD)	STUDENT #

Using a checkmark (✓), please indicate the program(s) or service(s) that the student has received.
Please draw a line through any grades (if known) that the student has not attended at your school.

PROGRAM/SERVICE	**K**	**GR 1**	**GR 2**	**GR 3**	**GR 4**	**GR 5**	**GR 6**	**GR 7**	**GR 8**	**GR 9**	**GR 10**	**GR 11**	**GR 12**
Medical Alert													
Counselor													
Hearing Impaired Services													
Individual Education Plan													
SMART GOAL													
Occupational Therapist													
Physiotherapist													
Psychologist													
Special Education Assistant													
Speech/Language Services													
Visually Impaired Services													

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