TUSCOLA INTERMEDIATE SCHOOL DISTRICT
Student Assistance Team
Meeting Summary/Action Plan

Student's Name:_____ Date of Meeting:_____

Team Members Present

_____ _____
Name/Title Name/Title

_____ _____
Name/Title Name/Title

_____ _____
Name/Title Name/Title

_____ _____
Name/Title Name/Title

Significant Findings

_____
_____
_____
_____

Action Plan

Problem Area(s)	Alternative(s) to be Tried	Person Responsible

Is additional data needed to establish intervention plan? ____Yes ____No

Type of Data to be Collected	Person Responsible

Action Plan Recommendation

Based upon review and evaluation of the concern(s) and information/ assessments, this student assistance team recommends that the following plan be developed (Please check one):

☐ Follow-up meeting to review action plan. Date: _____

☐ Develop behavior intervention plan. Date: _____

☐ Section 504 Referral. Suspected handicapping condition:

_____

Date of 504 plan meeting: _____

☐ Special Education Referral. Suspected special education eligibility:

_____

☐ A plan recommendation cannot be made at this time due to the need for additional information/assessment(s). Recommendations for additional information/assessments and person(s) responsible for collecting:

_____

_____

This meeting will reconvene on: _____