

Baltimore County Public Schools
STUDENT SUPPORT TEAM SUMMARY FORM

Student's Name:

DOB:

Grade:

School:

Referred by:

Date of SST Meeting:

Areas of Concern:

- | | |
|--|---|
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Inattention | <input type="checkbox"/> Math |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Speech/Language |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Work Completion |
| <input type="checkbox"/> Social | <input type="checkbox"/> Homework |
| <input type="checkbox"/> Emotional | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Medical | |

Summary of additional information reviewed at meeting:

Outcome of the SST meeting:

Follow-up:

Person(s) Responsible:

Develop Student Support Plan

Develop 504 Plan

Request SST Assessments (*Attach copy of permission form*):

Refer to Maryland School Assistance Program (MSAP):

Refer to IEP Team

Other (*specify*):

Copy of this form should be given to referring teacher or staff member.