



**Diocese of St. Petersburg**

**Student Support Plan**

Early Childhood through Grade 12

**Date of Initiation of SSP:**       **Date of Professional Evaluation:**       **Date of** **Re-evaluation:**

**Student’s Name:**  **Date of Birth:**      

**Grade/Teachers:**

     

**School Name:**       **Current Date:**      

**Student’s Strengths:**

**Name of Physician/Evaluator:**       **Phone:**

**Diagnosis:**

**Medical/Physical Condition (as applicable):**

**Emergency Procedure/Information:**  See attached  Not Provided  N/A

**Medication(s):**  Yes  N/A

Name of Medication:       Dosage:

When Administered:

Name of Medication:       Dosage:

When Administered:

**Documentation of special learning needs on file (assessment tools including: date, diagnostician, scores and diagnosis results): Check all that apply**.

School Counselor  ESE  Electronic  Other

**Describe impact of special learning need on education performance:**

**Parent/Guardian’s Name:**      

(H) Phone:       (C) Phone:       (W) Phone:

E-mail address:

**Parent/Guardian’s Name:**      

(H) Phone:       (C) Phone:       (W) Phone:

E-mail address:      

**Student’s Name:**       **Date:**

**School** offers reasonable accommodations when a professional diagnosis with supporting documentation is presented to the support team. The school does not implement the public school IEP.

**ARRANGEMENT OF ROOM**

Choose an item.

Choose an item.

Choose an item.

Choose an item.

**Other:**

**FOLLOWING DIRECTIONS**

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

**Other:**

**LESSON DELIVERY**

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

**Other:**

**LESSON COMPLETION**

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

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Choose an item.

Choose an item.

Choose an item.

**Student’s Name:**       **Date:**

Choose an item.

Choose an item.

**Other:**

**ASSESSMENT PROCEDURES AS NEEDED**

* *Follow Grading Policy ATL’s*
* *Follow the standardized testing guidelines set by the Diocese of St. Petersburg*
* *NOTE: EXTENDED TIME IS LIMITED TO NO MORE THAN 50% OF THE OFFICIAL ALLOTTED TIME*
* ***Additional extended time for high school only:***
  + *Time and a half, or 50 percent additional time for the new SAT is 4 hours and 30 minutes without the essay, and 5 hours and 45 minutes for the new SAT  Essay*
  + *Double time, or 100 percent additional time is 6 hours on the new SAT without the essay, and 7 hours and 40 minutes for the new SAT Essay*
    - In order for a student to apply for option #2 of the **high school only**, it has to be present in the SSP.

Choose an item.

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Choose an item.

**Other:**

**SUPPORT MATERIALS FOR ASSESSMENTS**

Choose an item.

Choose an item.

Choose an item.

**Other:**

**ORGANIZATION**

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

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Choose an item.

Choose an item.

Choose an item.

Choose an item.

**Student’s Name:**        **Date:**

Choose an item.

Choose an item.

**Other:**

**BEHAVIOR**

Choose an item.

Choose an item.

Choose an item.

Choose an item.

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Choose an item.

Choose an item.

**Other:**

**SPECIAL CONSIDERATIONS**

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

Choose an item.

**Other:**

**STUDENT’S RESPONSIBILITIES**

Complete all assignments and submit them on time

Inform teacher if extra time is needed

Come to class on time, prepared and with all materials

Maintain appropriate behavior in class

Seek teacher assistance as needed during class

Seek extra help before, after school or during lunch

Record assignments in agenda/planner/electronic device

Check on-line portal daily

**Other:**

**Student’s Name:**       **Date:**

**PARENT’S RESPONSIBILITIES**

Ensure that student is in school and on time each day

Monitor child’s study habits, work completion and progress

Check on-line portal as needed

Support lesson completion, organization and special considerations accommodations in the home environment

Provide updated documentation regarding student’s diagnosis at least annually

Maintain open communication with teachers and administration

Address all problems with subject area teacher first

Support teachers in formulating and enforcing strategies to improve student’s academic performance, behavior,

responsibility, organization and success

Follow evaluator’s recommendations as provided in report

Professional re-evaluation every 3 years or at the recommendation of the school

**Other:**

**Student’s Name:**       **Date:**

**AFFIRMATION OF STUDENT SUPPORT TEAM MEETING**

**Parent Affirmation**

I /We agree with the results of this Student Support Team meeting and accept the accommodations to be

implemented and the responsibilities as outlined. We also understand that the child must be professionally

re-evaluated on or before this date

I/We disagree with the results of this Student Support Team meeting and do not provide permission to

implement the accommodations and responsibilities as outlined.

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Parent/Guardian Date Parent/Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student (as appropriate) Date

**The signatures below indicate participation in this Student Support Team Meeting**

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School/Center Administrator Date Teacher Date

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School Counselor Date Teacher Date

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Academic Support/Resource Teacher Date Teacher Date

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Teacher Date Other Date

**Additional Information**: