SCHOOL and COMMUNITY CONFERENCE ARRANGEMENTS

Children with Special Health Care Needs, ABLE Program
Box 144660, SLC UT 84114-4660 (584-8552)

DATE Submitted:__________ **Client**____________________ **DOB**_________ **Age**________ **Grade** ____________

Conf Location________________________________ **Address**____________________________________

School Phone #___________________ **School District**___________________ **Year Round**_______________

Conf Date______________________ **Weekday**_________________ **Time**______________ **Car**__________

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Tentative Date _____________ **Weekday** ______________________ **Tentative Time** __________________

Parent willing to help set up conference

Attended

Confirmed **ABLE Staff**______________________ □ _________________ □ _________________ □

□ ____________________________________ **Position**_________________________ **ph** _________________ □

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□ ____________________________________ **Position**_________________________ **ph** _________________ □

Reason for conference____

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Conference requested by____________________________________ **phone** ________________________

Child initially referred by____

SCHOOL CONFERENCE STAFFING

Name_____ **Date**_____ **School**_____
Grade_____ **Record Review**_____
Diagnosis_____
Attendance and reason for meeting (see other side)

Background Information and History:

Findings and Observations:_____

Medical Exam of Child: _____

Strengths:_____

Concerns and Challenges:_____

Plans: ***(who is to carry out what, and when?)***

Follow-up Meeting_____ **Conference form completed by: Recorder**_____