

STUDENT PROFILE

A	Name of Student	Last Name	First	Middle
	Date of Birth	Month Day Year ____/____/____	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Date of CSE Recommendation for Residential Placement		Month Day Year ____/____/____	
	With the consent of parent, has the CSE made a referral to the Office for People With Developmental Disabilities (OPWDD)?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	Parent <input type="checkbox"/>	Last Name	First	Home Telephone Number ()
	Legal Guardian <input type="checkbox"/>			Work Telephone Number ()
	Address	Street		
	City	County	State	Zip
	School District			
	District Contact	Last Name	First	
	Title			Telephone Number ()
	Address	Street		Fax Number ()
	City	County	State	Zip
B	Request for Out-Of-State Placement:			
	<input type="checkbox"/> Initial Placement		<input type="checkbox"/> Reapplication	
	<input type="checkbox"/> Change in Residential Placement		<input type="checkbox"/> Change in CSE Responsible District	
<p>_____</p> <p>Signature, CSE Chairperson</p> <p>_____</p> <p>Date</p>				

C	Name of <u>Current</u> Educational Program (not proposed program):	
	(Please check the appropriate box below)	
	<input type="checkbox"/> Public School in District	<input type="checkbox"/> State-operated School
	<input type="checkbox"/> Public School Not in District	<input type="checkbox"/> State-supported School
	<input type="checkbox"/> BOCES Center-based Program	<input type="checkbox"/> Special Act School District
	<input type="checkbox"/> BOCES Program in local educational agency	<input type="checkbox"/> Approved In-State Private School
	<input type="checkbox"/> Home Instruction	<input type="checkbox"/> Approved Out-of-State Private School
	<input type="checkbox"/> Hospital Instruction	<input type="checkbox"/> Emergency Interim Placement
	Name of Hospital _____	<input type="checkbox"/> Other State Agency Program
D	CSE Classification: (Please check ONE box to indicate the primary disability classification made by the CSE)	
	<input type="checkbox"/> Autism	<input type="checkbox"/> Learning Disability
	<input type="checkbox"/> Deafness	<input type="checkbox"/> Multiple Disabilities* (see below)
	<input type="checkbox"/> Deaf-Blindness	<input type="checkbox"/> Orthopedic Impairment
	<input type="checkbox"/> Emotional Disturbance	<input type="checkbox"/> Other Health Impairment <i>Description:</i>
	<input type="checkbox"/> Hearing Impairment	_____
	<input type="checkbox"/> Intellectual Disability	_____
		<input type="checkbox"/> Speech or Language Impairment
		<input type="checkbox"/> Traumatic Brain Injury
		<input type="checkbox"/> Visual Impairment, including blindness
*If student is classified with <u>multiple disabilities</u>, identify the two or more concomitant impairments		
	<input type="checkbox"/> Autism	<input type="checkbox"/> Intellectual Disability
	<input type="checkbox"/> Deafness	<input type="checkbox"/> Orthopedic Impairment
	<input type="checkbox"/> Deaf-Blindness (when combined with another disability)	<input type="checkbox"/> Other Health Impairment <i>Description:</i>
	<input type="checkbox"/> Emotional Disturbance	_____
	<input type="checkbox"/> Hearing Impairment	_____
		<input type="checkbox"/> Traumatic Brain Injury
		<input type="checkbox"/> Visual Impairment, including blindness

E Student Functioning Level: Results of Latest Test of Intelligence
(Check the box that most closely indicates the results)

Intellectual ability	Adaptive Functioning	Language Functioning
<input type="checkbox"/> Average to above average intelligence	<input type="checkbox"/> Independent; within normal limits	<input type="checkbox"/> Receptive and expressive language skills within normal limits
<input type="checkbox"/> Mild intellectual disability	<input type="checkbox"/> Capable of looking after own everyday needs	<input type="checkbox"/> Mild disabilities in understanding and communicating
<input type="checkbox"/> Moderate intellectual disability	<input type="checkbox"/> Needs assistance with personal grooming and independent living skills	<input type="checkbox"/> Significant disabilities in understanding and/or communicating
<input type="checkbox"/> Severe or profound intellectual disability	<input type="checkbox"/> Highly dependent on support from others to complete basic living skills	<input type="checkbox"/> Nonverbal

Special Considerations:

- Does this student require a sign language interpreter? Yes No
 Does this student require instruction in Braille and the use of Braille? Yes No
 Does the student require bilingual special education? Yes No

Physical Functioning:

- Vision:** Vision normal (includes vision corrected to normal)
 Visually impaired
 Legally blind, has travel vision
 No functional vision
- Needs services of Teacher of Visually Impaired
 Needs services of Teacher of Orientation & Mobility
- Hearing:** Hearing normal (including hearing corrected to normal)
 Hearing impaired
 No functional hearing
- Needs services of Teacher of the Hearing Impaired

- Mobility:** Walks independently Walks with supportive devices
 Walks unaided with difficulty Wheelchair – needs assistance
 Wheelchair – operated by self No mobility

Medical Diagnosis: (Indicate any medical problems which may impact on the education of the child)

- | | | |
|---|--|---|
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Tourette Syndrome |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Oppositional Defiant Disorder | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Anxiety Disorder | |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Mood Disorder | |
| <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Psychotic Disorder | |
| <input type="checkbox"/> Medically Fragile | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Neurological Impairment | | |
| <input type="checkbox"/> Prader-Willi | | |

Medical Needs:

Does this child have medical needs beyond the administration of medications which require daily individualized attention from health care staff? Yes No

Does this child require 24-hour nursing care? Yes No

Please specify any medical alerts: _____

Behaviors Exhibited: (Indicate any behavior problems which may impact on the education of the child)

- | | |
|--|--|
| <input type="checkbox"/> Aggressive to others | <input type="checkbox"/> Easily victimized |
| <input type="checkbox"/> Self-abuse | <input type="checkbox"/> Emotionally fragile |
| <input type="checkbox"/> Property destruction | <input type="checkbox"/> School phobia |
| <input type="checkbox"/> Sexually inappropriate | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> History of fire setting | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Incidental | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chronic | |

Behavior Frequency:

- Has no behavior disorder that requires individualized programming
- Has monthly maladaptive behaviors that require individualized programming
- Has weekly maladaptive behaviors that require individualized programming
- Has daily maladaptive behaviors that require individualized programming

F Related Services Recommended:

- | | |
|--|---|
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Psychological Services |
| <input type="checkbox"/> Assistive Technology Services | <input type="checkbox"/> Parent Counseling and Training |
| <input type="checkbox"/> Counseling Services | <input type="checkbox"/> Rehabilitation Counseling |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> School Health Services |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> School Social Work |
| <input type="checkbox"/> Speech Pathology | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Medical Services (evaluation) | |

G Diploma goal: Regular high school diploma Other: (please specify): _____