Guam Department of Education
Form D: Child Study Team I Special Program Input

FORM TO BE COMPLETED BY: ESL Teacher/Coordinator and School Counselor

(Revised 6/17/24)

Date Completed:

Student:	**Student #:**

The exam/screening information shall be completed by the School Counselor, ESL Coordinator, and/or designee and forwarded to the Child Study Team (CST) Facilitator for review and to assist the CST on what additional data, if any, is needed.

School Counselor Name:

Supportive Counseling ☐ Yes ☐ No

Does the student have a Behavioral Intervention/Management Plan? ☐ Yes ☐ No

Provide a summary of the counseling services and supports provided for the student, include all pertinent information, such as contacting the school psychologist, or other behavioral supports.

ESL Coordinator/Teacher Name:

ESL ☐ Yes ☐ No

Date of Entry:

Date of Modification:

Home Language Survey attached: ☐ Yes ☐ No

Primary Language:

LAS (if applicable) attached: ☐ Yes ☐ No

Provide a summary of services provided for the student or other relevant information to be considered by the CST.

Other information considered or reviewed: