



# Chilliwack School District Middle School Entry Document

\_\_\_\_\_ **Previous School**

to

\_\_\_\_\_ **Middle School**

Affix demographic label here

P.E.N. #: _____ Last Name: _____ First Name: _____ Prefers to be called: _____ Gender: M or F D.O.B.: _____ Parent/Guardian: _____ Address: _____ Home Telephone: _____ _____ Email: _____ International Student: Country _____ Language _____ Grade 6 (or previous) Teacher: _____	<input type="checkbox"/> Ministry Category: _____ <input type="checkbox"/> Diagnosis: _____ <input type="checkbox"/> Medical Alert <input type="checkbox"/> Medication: _____	<div style="border: 1px solid black; background-color: #cccccc; height: 100px; width: 100%;"></div> <p><b>Student Photo</b></p>
IEP: <input type="checkbox"/> Academic <input type="checkbox"/> Behaviour <input type="checkbox"/> Health		<p><b>* Please attach IEP, Medical Alert Information &amp; Transition Meeting Minutes</b></p>

Completed by Classroom Teacher

<b>Achievement</b>												
Subject	Mark	Effort	✓ If Adapted	✓ If Modified		G	S	N		G	S	N
Reading					Work Habits				Behaviour in class			
Writing					Homework				Behaviour out of class			
Math					Organization				Empathy			
					Leadership				Cooperation			

**Strengths & Interests:** (eg. sports, fine arts, etc.) \_\_\_\_\_

**Concerns:** \_\_\_\_\_

Completed by the Elementary SBT

<b>School Services Received</b> in Elementary <input type="checkbox"/> Learning Assistance <input type="checkbox"/> First Nations Support <input type="checkbox"/> T.A. <input type="checkbox"/> S.B.T. <input type="checkbox"/> Care Team <input type="checkbox"/> E.S.L. <input type="checkbox"/> Other: _____	<b>District Services</b> in Elementary <input type="checkbox"/> Speech & Language <input type="checkbox"/> Counsellor <input type="checkbox"/> O.T. <input type="checkbox"/> P.T. <input type="checkbox"/> School Psychologist <input type="checkbox"/> Resource Teacher <input type="checkbox"/> D.B.F. (Gr. ____) <input type="checkbox"/> Teacher of the Visually Impaired <input type="checkbox"/> Teacher of the Deaf & Hard of Hearing <input type="checkbox"/> Hospital Homebound (Gr. ____) <input type="checkbox"/> District L.D. Resource Program (Gr. ____) 	<b>Recommended Services/Program</b> <input type="checkbox"/> Learning Assistance <input type="checkbox"/> First Nations Support <input type="checkbox"/> T.A. <input type="checkbox"/> S.B.T. <input type="checkbox"/> Care Team <input type="checkbox"/> E.S.L. <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
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**Middle School Case Manager:** (Name & Position) \_\_\_\_\_ **Place away from/with:** \_\_\_\_\_

**Recommended Placement:** Advisory \_\_\_\_\_ Humanities \_\_\_\_\_ Sci-Math \_\_\_\_\_

**Form Completed by:** \_\_\_\_\_  
 March2003

**Date:** \_\_\_\_\_

**Revised**

