Stanislaus County Office of Education
Tom Changnon, Superintendent

Child & Family Services

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Results of Child Success Team Meeting

Date: _____

Child: _____ Date of Birth: _____ Educator: _____

Service Option (Circle One): Center Based Home Base FCCH Location: _____

Parent / Guardian: _____ Interpretation By: _____

Participants: _____

_____

Meeting Purpose: _____

Meeting Highlights: _____

_____

_____

_____

_____

_____

_____

_____

White: Grantee Disabilities Supervisor / Designee (RHS/EHS)
White: Delegate Disabilities Coordinator (MSHS)

Yellow: Child File

Pink: Parent

(List strategies to support areas of concern, building on strengths, and support from staff and outside agencies.)

Plan of Action: Strategies	Timeline	Person Responsible	C	H

Key: **C** - Class/FCCH **Child's name:** _____ **Educator:** _____
H - Child's Home

White: Grantee Disabilities Supervisor / Designee (RHS/EHS) Yellow: Child File Pink: Parent
White: Delegate Disabilities Coordinator (MSHS)

Follow-up:

Choose all that apply:

- ☐ **Parent Conference (Educator/Parent)** _____ Date
- ☐ **Child Success Team Meeting (Head Start Staff/Parent**)** _____ Date
- ☐ **Observation / Case Management (Head Start Staff**)** _____ Date
- ☐ **Other** _____

_____

**Mental Health consultants and/or special education professionals may also attend these meetings as needed.

Parent Consent:

___ The CST Results form was reviewed by _____and I received a copy.
(Print CST Members name reviewing form)

___ I agree for my child to be referred for special education services.

___ I agree for my child to be referred for an individual social emotional observation (observation permission form also required).

___ I decline the offer to have my child referred for special education services.

___ I decline the offer to have my child referred for an individual social emotional observation.

___ I have been given medical education and/or referrals regarding my child's health concern.

Parent Signature:_____ Date:_____