ACADEMIC SUPPORT GOAL SHEET

Student Information

(Complete this section with the classroom teacher)

Date of Meeting: _____

Tutor: _____ Classroom Teacher: _____

Student Name: _____ Grade: _____ School: _____

Referral made for the following academic supports (**choose one**): _____ Reading _____ Mathematics

Student Strengths: _____

Areas of Concern: _____

Goals/Objectives for Academic Support in above area (prioritize one area):

1._____

2._____

Name of Assessment: _____

Pre-Assessment Date: _____ Pre-Assessment Score: _____

Copy to: _____ Teacher _____ Principal _____ ASP Coordinator

Summary of Academic Support

Assigned Support Days (circle): M T W Th F

Tutor/student ratio (circle one): 1 – 1 1 – 2 1 – 3 1 - 4

Dates Student Attended Support Sessions: _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Accomplishments related to goals: 1. _____

2. _____

Post-Assessment Date: _____ Post-Assessment Score: _____ Tutor Initials: _____

Recommendation for Continued Support: _____ Additional Support Needed _____ Not Needed at This Time

At conclusion, copy with related information to: ____ Teacher ____ Parent ____ Principal ____ ASP Coordinator