

Student Learning Profile

This form should be completed by the child's teacher and parent/guardian together, with other people optional

Student Name: _____

School: _____

Date of Birth: _____

Student ID number: _____ Year/Grade: _____

Date this form completed: ____ / ____ / 20____

Teacher completing the form: _____

TPF of teacher completing the form: _____

Other people involved in completing the form:

Parent/guardian: Name: _____

Relationship to child: Mother / Father / Guardian

Other (please specify): _____

Other person involved in completing the form:

Name: _____

Relationship to child: Teacher Aide / School Counsellor / Inclusion Coordinator / Other
(please specify): _____

Other person involved in completing the form:

Name: _____

Relationship to child: Teacher Aide / School Counsellor / Inclusion Coordinator / Other
(please specify): _____

Q1) Is the child currently using any of the following types of assistive device(s)?

(Tick all applicable options; refer to the pictures of assistive devices in the Training Manual if required; if the child uses NONE of these, please tick option 1.12)

1. ☐ Glasses (or contact lenses)
2. ☐ Hearing aid
3. Mobility aid:
 - a. ☐ Wheelchair
 - b. ☐ Crutches, walking stick or walking frame
 - c. ☐ Other mobility aid, please specify: _____
4. ☐ Braille machine (child reads by touching the bumps on the machine or page)
5. ☐ Screen reading software (computer program reads the text out loud)
6. ☐ White cane (for low-vision or blind children)
7. ☐ Orthotic devices (to support legs, arms or spine)
8. ☐ Artificial limbs (prosthetics)
9. ☐ Modified furniture (eg. special chair or desk; modified height of desk)
10. ☐ Communication boards (e.g. a board with pictures children point to and express themselves)
11. ☐ Others (Please specify)
12. ☐ No Assistive Device used

Q2) Does the child receive any human assistance for walking or moving?

Circle: Yes / No

Describe:

Tick one column for each row. For detailed descriptions of each category, please refer to Table 1 of the FEMIS Disaggregation Manual

Q3) Compared with children the same age in the general population, does (name of child) have difficulty in the following areas:			No difficulty	A little difficulty*	A lot of difficulty*	Cannot do at all*	*Please write a short description of the difficulty
		EXPLANATION					
3a	Seeing	Difficulty seeing things close up or far away, like objects, faces or pictures. <i>If the child wears glasses, does the child have difficulty seeing even when wearing the glasses?</i>					
3b	Hearing	Difficulty hearing sounds like peoples' voices or music. <i>If the child wears hearing aids, does the child have difficulty hearing even when using hearing aids?</i>					
3c	Gross motor actions	Difficulty walking or climbing stairs					
3d	Fine motor actions	Difficulty using hands and fingers, such as picking up small objects, for example, a button or pencil, or opening and closing containers or bottles?					
3e	Speaking	Difficulty being understood when speaking (in the language that is most usual for the child)					
3f	Learning (general)	Difficulty with general intellectual functions such as learning and remembering. <i>Includes learning a range of things related to school, play, tasks at home, etc.</i>					
3g	Learning (specific)	Difficulties in specific learning areas within literacy or numeracy, eg. dyslexia or dyscalculia. <i>Child learns most other things normally or above average. Read guidelines carefully, rule out other conditions and factors. ** No difficulty or Not Applicable</i>	**				
3h	Behaviour/ Attention / Socialisation	Difficulty controlling his/her own behaviour, and/or focusing and concentrating, and/or accepting changes in routine, and/or making friends					
3i	Emotions	How often does the child seem: Very sad and depressed, and/or very worried and anxious? <i>¹Rarely = never or just a few times/year</i>	Rarely ¹	Monthly	Weekly	Daily*	

In addition, if the child has difficulties in areas that are not listed above, or if the child's functional status has changed, please include additional information here:

Learning support needs

Personal Assistance *(assistance from a human, not due to assistive devices)*

Q4) Compared with children the same age, how much personal assistance at school does the child require with any of the following tasks? *(answer all rows; for each row tick one column only.)*

	Needs no extra assistance	Needs a <u>little</u> more assistance than other children *	Needs <u>much</u> more assistance than other children *	*Please provide a short description of the kind of assistance required.
4a. Moving around the classroom				
4b. Moving around outside in the school grounds				
4c. Getting to and from school				
4d. Communication				
4e. Cognitive / learning activities				
4f. Self-care (eating, toileting)				
4g. Socialising with other children				
4h. Managing own behaviour				

Q5) Record adaptations to learning or assessment that you currently make for this student? *Tick a column for every question.*

	Yes, we do this *	No need for this	Not done, but there might be a need *	*Please provide information to explain your response.
5a. Child sits close to the board or teacher				
5b. Printed materials are enlarged				
5c. Printed materials are provided in Braille				
5d. Physical education (sport) activities and games are modified				
5e. Modifying the lesson, or reducing the complexity of the lesson for the child				
5f. Sign language interpreters are available for this child for learning & other school activities				
5g. Additional time provided for assessments (exams, tests)				
5h. Assistance during assessments (eg. note taker, sign language interpreter)				
5i. Child receives support from a Teacher Aide				
5j. School staff provide education to the child at home				
5k. Other				
5l. Other				

Other Information

Q6) Does the student have an Individual Education Plan (IEP)? Please circle: Yes / No / Not yet, but we plan to develop one

Q7) Any other comments, including additional information related to the child's disability, or to education supports required: If you feel that the situation or needs of this child are not adequately captured in the above information, please describe his or her situation and additional requirements.

Q8) What are the student's strengths/capabilities and interests?

Recommendations and Follow Up required

Q9) Please record: Recommendations and follow up actions required, including any referrals required (and who is responsible for the action)

Student Learning Profile – Part 2: Clinical, Diagnostic and Treatment Information

Please record any clinical, diagnostic and treatment information. *Please use multiple rows to include ALL conditions. This section should only be completed if there have been assessments by doctors, therapists, audiologists, vision specialists, or other medical services.*

A. Clinical Condition / Diagnosis (eg. Cerebral palsy, Autism spectrum disorder, Profoundly hearing impaired, etc)	B. Year of diagnosis	C. Name of practitioner or service that made the diagnosis	D. Copy of report attached?	E. Services received for this condition	F. Approx. date of service	G. Is there a need for further services for this condition? Please name as many as required.	H. Results from services. This column should be completed when student has attended or received services in Column G.