

**Student Profile for SET-BC Student Based Support**

**Student Information**

Has had previous SET-BC services:  Yes  No

Surname:	Given Name:	School:
Grade (2020-2021):	Preferred Pronoun: <input type="checkbox"/> He <input type="checkbox"/> She <input type="checkbox"/> They	
PEN # (9 digits):	Birthdate (DD/MM/YY):	
Diagnosis / SPED Category:		
Barriers to accessing curriculum (check all that apply and add more detail below): <input type="checkbox"/> Communication <input type="checkbox"/> Vision <input type="checkbox"/> Cognitive/Academic <input type="checkbox"/> Motor <input type="checkbox"/> Social / Behavioural		
Student is receiving the following services (check all that apply): <input type="checkbox"/> Speech-language services <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> TSVI Services <input type="checkbox"/> Services for the hearing impaired <input type="checkbox"/> Autism / Behaviour consultant		

**Student Team Information**

Team Member Name	Role in District /School	Email	Phone Number
	School Administrator		
	Classroom Teacher for <b>upcoming</b> school year (if known – leave blank otherwise)		
	Key Contact/Position (school-based)		

**Student Profile (Complete only the sections that are relevant to the student)**

<p><b>Communication Concerns:</b> <input type="checkbox"/> Yes (attach all relevant reports if available) <input type="checkbox"/> No (If no, do not complete this section.)</p> <p>Speech/Language:  <input type="checkbox"/> Speaking <input type="checkbox"/> Language difficulties <input type="checkbox"/> Articulation difficulties  <input type="checkbox"/> Non-Speaking: Communicates by (explain briefly below)  <input type="checkbox"/> Gesturing/pointing <input type="checkbox"/> Sign language <input type="checkbox"/> Picture Exchange Communication System  <input type="checkbox"/> Communication boards/books <input type="checkbox"/> Low Tech Speech Device (Big Mac, etc)  <input type="checkbox"/> High Tech Speech Generating Device (e.g. iPad)</p>
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Other (specify):

What are the student's primary modes of communication?

**Vision Concerns:**  Yes (attach all relevant reports if available)  No (If no, do not complete this section.)

Vision Impairment:  Low Vision  Visual Field Restrictions  Colour Vision Deficit  
 Blind  Cortical Visual Impairment  Progressive Condition

Optical Aids Used (describe): Preferred Magnification \_\_\_\_\_

Acuity Right Eye: \_\_\_\_\_ Left Eye: \_\_\_\_\_ Both Eyes: \_\_\_\_\_

Reading Medium  Large Print  Large Print with Speech Preferred Font Size \_\_\_\_\_  
 Uncontracted Braille  Contracted Braille

Student Ability  Low Vision Clinic (include report) Typing Speed \_\_\_\_\_ wpm

**Cognitive / Academic Concerns:**  Yes (attach any relevant reports if available)  No (If no, do not complete this section.)

Cognitive level:  Average/above average  Mild/moderate delay  Severe/profound delay

Pre-academic skills (describe if applicable):

Recognizes:  Objects  Photos  Line drawings

Has choice making ability:  Yes  No

Has visual matching skills:  Yes  No

Academics (expectations for grade/age):

Reading	<input type="checkbox"/> Exceeds	<input type="checkbox"/> Meets	<input type="checkbox"/> minimally meets	<input type="checkbox"/> not yet meeting
Reading comprehension	<input type="checkbox"/> Exceeds	<input type="checkbox"/> Meets	<input type="checkbox"/> minimally meets	<input type="checkbox"/> not yet meeting
Written language	<input type="checkbox"/> Exceeds	<input type="checkbox"/> Meets	<input type="checkbox"/> minimally meets	<input type="checkbox"/> not yet meeting
Math / numeracy	<input type="checkbox"/> Exceeds	<input type="checkbox"/> Meets	<input type="checkbox"/> minimally meets	<input type="checkbox"/> not yet meeting

<b>Motor Concerns:</b> <input type="checkbox"/> Yes (attach all relevant reports if available) <input type="checkbox"/> No (If no, do not complete this section.)	
Mobility: <input type="checkbox"/> Walks independently <input type="checkbox"/> Walker/crutches/cane <input type="checkbox"/> Power wheelchair <input type="checkbox"/> Manual wheelchair <input type="checkbox"/> Other	
Hand function: <input type="checkbox"/> Effective <input type="checkbox"/> Impaired <input type="checkbox"/> Non-Functional	
Dominant hand: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both Comments:	
Writing/printing speed: _____ wpm            Typing speed: _____ wpm	
Support required for writing: <input type="checkbox"/> Scribe <input type="checkbox"/> Regular mouse <input type="checkbox"/> Extra time <input type="checkbox"/> Reduced workload	
Uses: <input type="checkbox"/> Regular keyboard <input type="checkbox"/> Joystick <input type="checkbox"/> Trackball <input type="checkbox"/> Regular pencil <input type="checkbox"/> Adapted pencil grip <div style="border: 1px solid black; padding: 5px;"> <input type="checkbox"/> Alternate keyboard    <input type="checkbox"/> Head pointer            <input type="checkbox"/> Hand switch    <input type="checkbox"/> Head switch            <input type="checkbox"/> Other switch sites  <input type="checkbox"/> Eye Gaze System           </div>	
<b>Social/Behavioural Concerns:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, do not complete this section.)	
<input type="checkbox"/> Peer Interactions <input type="checkbox"/> Time on Task / Attention <input type="checkbox"/> Work Productivity <input type="checkbox"/> Impulsivity <input type="checkbox"/> Safety	
Comments:	

Currently using assistive technology <input type="checkbox"/> No	<input type="checkbox"/> Yes (detail)
Referred to School-Based Team? <input type="checkbox"/> No	<input type="checkbox"/> Yes (detail)
Assessed by District Specialist(s)? <input type="checkbox"/> No	<input type="checkbox"/> Yes (include report)
Assistive Technology has been trialed? <input type="checkbox"/> No	<input type="checkbox"/> Yes (detail)

Current IEP attached (*Required)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Short video of student in class submitted. It is not mandatory to submit a video.	<input type="checkbox"/> No	<input type="checkbox"/> Yes (detail):

**SET-BC Services Requested** – Please select one:  
 (Full scope of services to be provided will be determined during Collaborative Action Plan Meeting)

Assistive Technology Loan and SET-BC Educator Support  
 SET-BC Educator Support for existing Assistive Technology Loan  
 Assistive Technology Loan Only

Main goal(s) that you would like SET-BC support with:

Is there any other information that you think would be helpful for SET-BC to know about the student?

School Administrator:	Signature:
District Partner:	Signature:

SET-BC Provincial Review	<input type="checkbox"/> Approved for CAP <input type="checkbox"/> Not Approved Date (DD/MM/YY):
<b>Review Notes:</b>	