SPECTRA

NEW STUDENT FORM

USD#_____

Local Education Agency Name: **Tri-County Special Education Interlocal #607**

KIDS ID#_____

Student's Name: _____

Last First MI

Student's Second Name: _____

(if applicable) Last First MI

Gender: M F Date of Birth: _____

Therapist Name: ***(Fill in all that apply)***

Speech Language Pathologist_____

Audiologist_____

Occupational Therapist_____

Certified Occupational Therapy Assistant_____

Physical Therapist_____

Physical Therapy Assistant_____

Registered Nurse_____

Registered Nurse Attendant Care_____

Licensed Practical Nurse_____

Licensed Practical Nurse Attendant Care_____

Attendant Care Provider_____

Extended Learning Provider_____