2008-2009 Technical Assistance Profile (TAP)

Classroom Consultation

Upon receipt of this completed TAP and signed consent for each individual with autism in the classroom, you will be contacted by the KATC to schedule and initial observation of the classroom. This TAP paperwork should be filled out by the agency requesting technical assistance and training.

PLEASE SEND COMPLETED FORM AND CONSENT TO:

Kentucky Autism Training Center
ATTN: Kristen Frarey, School Services
College of Education and Human Development/Dean's Office
University of Louisville
Louisville, KY 40292

Tel: (800) 334-8635 ext. 852-4631
(502) 852-4631
Fax: (502) 852-7148
Email: Kristen.frarey@louisville.edu

KATC will work with a "Team Leader" in scheduling observations and training activities. This "Team Leader" will work hand in hand with the KATC Field Trainer and assist in the coordination and communication of all activities. The Team Leader will be determined prior to the initial observation.

Form Completed by: ____________________ Role: __________ Date: __________

Telephone/Fax: ____________________ E-mail: ____________________

School District: ____

Director of Special Education: ____________________ Telephone: ____________________

Team Leader Name: ____________________ Role: ____________________

Type of Classroom (ex. Resource, FMD): ____

08-09 School Consultation Charges are: $250/Half Day (3 hrs) and $500/Full Day (6 hrs.). Number of visits vary based on the needs of the team. Please indicate a contact name and address for the invoice to be sent.

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Please list names of all students with autism in this classroom. In addition, please complete the consent form on page 4 for each student with autism in the classroom and return it with this TAP.

Student Name: ____________________

Student Name: ____________________

Student Name: ____________________

Student Name: ____________________

Student Name: ____________________

Student Name: ____________________

Student Name: ____________________

Student Name: ____________________

Classroom Consultation

A staff member will travel out to the school and observe the classroom. The staff member will meet with the teacher and discuss strategies and techniques to be implemented within the classroom. The staff member will be looking for specific areas in relationship to best practices for students with ASD. A Training Agenda will be developed and training sessions will be scheduled. These areas may include: structure of the educational environment, incorporating the grade level curriculum, using fundamental teaching principals, implementing behavior plans, and collaborating.

1. In the space below, please describe the students in your class. For example, 3 boys with Autism 2 girls with Down's syndrome. Please include how many adults are in the class as well.

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2. Please describe your concerns with your classroom. Explain what you'd like to change. For example, incorporate visual schedules for all students, change the environmental design of the classroom, and implement a class-wide reinforcer system.

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3. What are the desired outcomes from the classroom consultation?

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COMMUNICATION TREE

In order for KATC staff to efficiently disseminate information and communicate with the local team, we ask to be provided with the following contact information. KATC asks that the team leader communicate any schedule changes to the team. Pre and Post evaluations of the consultations will be mailed to both the student's primary home address and the team leader. Please feel free to disseminate copies of the evaluations survey to team members. Thank you in advance for helping us continuously modify and evaluate our services. Your feedback will be kept confidential.

Team Member/Role	E-mail Address	Address	Telephone
Special Education Teacher			
Assistant			
Assistant			
Director of Special Ed.			
Parent/Guardian			
Other			
Other			

Consent for Release of Confidential Information

(Please fill out a consent form for each individual with autism in the classroom. Thank You)

Name:	____________________________	Grade:	_________________________________
Date of Birth:	____________________________	School:	_________________________________
Parent/Guardian:	____________________________	Address:	_________________________________
Primary Address:	____________________________		_________________________________
	____________________________	Telephone:	_________________________________
Telephone:	____________________________	Fax:	_________________________________
E-mail:	____________________________		
Fax:	____________________________		

Has this student been evaluated? YES NO If yes, where ______________________________________

Primary Diagnosis: ____________________________ Other Diagnosis: ____________________________________

I hereby freely give my permission for the release of information about my

child:_____________________________________, Date of Birth: _________________________

To be shared between these two agencies:

Agency:	Kentucky Autism Training Center	**AND**	Agency: ________________________________
Contact Person:	Kristen Frarey		Contact Person:____________________________
Address:	Kentucky Autism Training Center CEHD /Dean's Office University of Louisville Louisville, KY 40292		Address: ________________________________ ________________________________
Telephone:	502-852-4631		Telephone: ______________________________
Fax:	502-852-7148		Fax: ___________________________________

Indicate specific information to be released:

1. ____
2. ____
3. ____
4. ____
5. ____

Indicate the reason for this request and purpose for which this information will be used: ______________________

____

I certify that I am the parent or legal having custody of the student named above, or that I am the student named above (for students 18 years or older).

_______________________________________ _______________________________________

(Parent/Guardian/Student) (Date)

_______________________________________ _______________________________________

(Parent/Guardian/Student) (Date)