C.P.T.

Collaborative Planning Tool

Student Name:	**DOB:**
Meeting Participants:	**Date:**

STUDENT INFORMATION		
Student Name:	**School Year:**	**DOB:**
Parents' Names:	**Address:**	
Phone Numbers:	**Email:**	

ACADEMIC BACKGROUND	
Current (Religious) School:	**Grade:**
Teacher's Name (Religious School):	**Support/Related Services (at Religious School):**
Current (Secular) School and Grade:	**Support/Related Services (at Secular School):**

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Current Academic Level: (Briefly describe)

PREFERRED LEARNING STYLES

Visual ____ **Auditory ____**

Tactile ____ **Kinesthetic ____**

Details (how does student learn best):

INTERESTS/LIKES

Tangible:

Sensory:

Social:

Other:

DISLIKES

Tangible:

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Sensory:

Social:

Other:

Areas in Need of Support:
(What tasks or skills are difficult or frustrating for the student?)

Strengths: (student's interests, abilities, motivations)

Goals for this academic year: (parents' and/or student's in regards to Jewish education)

Short-term (3-6 months):

Long-term (by end of academic year):
Behavioral Concerns/Expectations:

We understand that this is not a legal or binding document. We are sharing this vital information about our child in an effort to make this year as successful as possible.

Signature of Parent(s):

Signature of Teacher(s)/Administrator/Staff:
