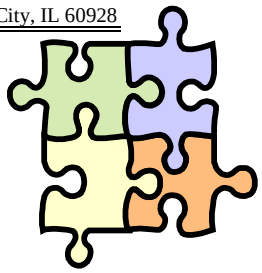
Iroquois Special Education Association

PO Box 400
100 S. Chestnut Street
Crescent City, IL 60928

Phone (815) 683-2662
Fax (815) 683-9913



Iroquois County Autism Support Team

If you are serving a student suspected of having autism and need support, you may seek assistance from the Iroquois County Autism Support Team. Attached is a referral form to be completed and sent to the Team Coordinator.

The team is multidisciplinary in nature, which provides different view points on the autism spectrum disorder. Some of the team members have been trained through TEACCH, PECS, sensory integration strategies, etc. Our mission is to provide training and consultation services to educators who need assistance with their students on the autism spectrum.

A resource library is currently under development at the ISEA office. Please contact Kimberly Miller at millerk@isea.k12.il.us if you would like reference materials on a certain subject. We may be able to provide you with a lending book or point you in the direction of resource materials.

Procedures for Obtaining Assistance

1. Complete the Referral for Autism Support and submit to Kimberly Miller, Team Coordinator, at ISEA.
2. Obtain parental permission/signature for assistance.
3. Provide any other specific areas of concern that you would like addressed.
4. Upon receipt of the referral, an Autism Support Team member will make contact to establish an observation/consultation date(s).

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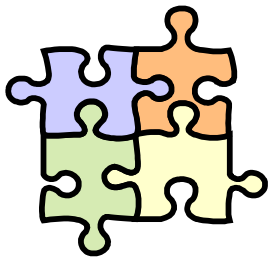

Iroquois County Autism Support Team

I understand that _____ (School) has recommended that my child, _____ (name of student) receive consultation and/or assistive services from the ICAST (Iroquois County Autism Support Team). Only with written consent will these services be provided. The Autism Support Team's purpose is to help families and staff with strategies and consultation for individual students' needs.

☐ I agree

☐ I disagree

to give the Autism Support Team permission to observe and provide assistance or consultation to my child.

_____ _____

Parent/Guardian Signature Date

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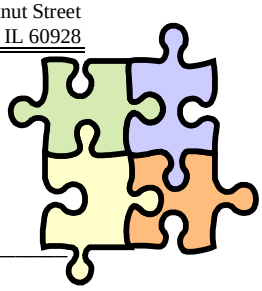

Referral Form
Iroquois County Autism Support Team

Date:_____ Referred by:_____

Name of Student:_____Resident District:_____

Gender: _____ Birth Date: _____School:_____ Grade: _____

Address: _____ Phone: _____

Lives with: _____ Relationship: _____

Father: _____ Cell/Work Phone: _____

Mother: _____ Cell/Work Phone: _____

Primary Language: Home_____Child_____Ethnicity:_____

Student's Mode of Communication: _____Proficient: _____Yes _____ No

Medications: _____

Current Diagnosis/Eligibility _____

Services received by student: _____

What would you like the Autism Support Team to do? (Please feel free to use the back of this document to note specific areas of concern that you are having) _____

_____

What interventions have been tried? _____

_____

Does the student have a visual schedule? What is the current means of communication? (Pictures, words, gestures, etc.)_____

_____

How can we contact you (referring agent's e-mail, phone number, etc.)? _____

_____

Principal's Signature: _____ Date: _____

Date of Parent Notification: _____

Referring Agent's Signature: _____ Date: _____