IEP Individualized Education Program

THIS IEP WILL BE IMPLEMENTED DURING THE REGULAR SCHOOL TERM UNLESS NOTED IN GENERAL FACTORS

CHILD'S INFORMATION

NAME: _____ ID NUMBER: _____

STREET: _____ GENDER: _____ GRADE: ____

CITY: _____ STATE: OH ZIP: _____

DATE OF BIRTH: _____

DISTRICT OF RESIDENCE: COUNTY OF RESIDENCE:

_____ _____

DISTRICT OF SERVICE:

_____

Will the child be 14 years old before the end of this IEP? YES ☐ NO
(Changes content of Sections 4 and 5)

Is the child a ward of the state? YES NO

If yes, provide the name of the surrogate parent:

PARENTS' / GUARDIAN INFORMATION

NAME: _____

STREET: _____

CITY: _____ STATE: OH ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

NAME: _____

STREET: _____

CITY: _____ STATE: OH ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

OTHER INFORMATION:

MEETING INFORMATION

MEETING DATE: _____

MEETING TYPE:

- INITIAL IEP
- ANNUAL REVIEW
- REVIEW OTHER THAN ANNUAL REVIEW

_____

- AMENDMENT
- OTHER _____

IEP TIME LINES

ETR COMPLETION DATE: _____

NEXT ETR DUE DATE: _____

IEP EFFECTIVE DATES

START: _____

END: _____

NEXT IEP REVIEW: _____

IEP BY 3rd BIRTHDAY ? YES NO
(If transitioning from EI services)

IEP FORM STATUS

(Check when complete)

1. FUTURE PLANNING
2. SPECIAL INSTRUCTIONAL FACTORS
3. PROFILE
4. POSTSECONDARY TRANSITION
5. POSTSECONDARY TRANSITION SERVICES
6. MEASURABLE ANNUAL GOALS
7. SPECIALLY DESIGNED SERVICES
8. TRANSPORTATION AS A RELATED SERVICE
9. NONACADEMIC AND EXTRA CURRICULAR
10. GENERAL FACTORS
11. LEAST RESTRICTIVE ENVIRONMENT
12. STATEWIDE AND DISTRICT TESTING
13. MEETING PARTICIPANTS
14. SIGNATURES

AMENDMENTS: (Complete only if amending the IEP)

IEP SECTION AMENDED	THE SCHOOL DISTRICT AND PARENTS HAVE AGREED TO MAKE THE FOLLOWING CHANGES TO THE IEP	DATE OF AMENDMENT	PARTICIPANT & ROLE

1 FUTURE PLANNING

2 SPECIAL INSTRUCTIONAL FACTORS

Items checked "YES" will be addressed in this IEP:

Does the child have behavior which impedes his/her learning or the learning of others?	YES	NO
Does the child have limited English proficiency?	YES	NO
Is the child blind or visually impaired?	YES	NO
Does the child have communication needs (required for deaf or hearing impaired)?	YES	NO
Does the child need assistive technology devices and/or services?	YES	NO
Does the child require specially designed physical education?	YES	NO

3 PROFILE

CHILD'S PROFILE:

4 POSTSECONDARY TRANSITION

FOR 14 YEARS AND OLDER
(or younger if appropriate)

A STATEMENT OF TRANSITION SERVICE NEEDS OF THE CHILD THAT FOCUSES ON THE CHILD'S COURSE OF STUDY

FOR 16 YEARS AND OLDER
(or younger if appropriate)

AGE APPROPRIATE TRANSITION ASSESSMENTS

Summarize the results of the age-appropriate transition assessment data in the space below, indicating the source of the assessment(s) and the relevant information for transition planning

5 POSTSECONDARY TRANSITION SERVICES

POSTSECONDARY EDUCATION AND TRAINING (optional for 15 and younger)

MEASURABLE POSTSECONDARY GOAL:			
COURSES OF STUDY:		NUMBERS OF ANNUAL GOAL(S)	
TRANSITION SERVICE/ACTIVITY	PROJECTED BEGINNING DATE	ANTICIPATED DURATION	PERSON/AGENCY RESPONSIBLE

EMPLOYMENT (optional for 15 and younger)

MEASURABLE POSTSECONDARY GOAL:			
COURSES OF STUDY:		NUMBERS OF ANNUAL GOAL(S)	
TRANSITION SERVICE/ACTIVITY	PROJECTED BEGINNING DATE	ANTICIPATED DURATION	PERSON/AGENCY RESPONSIBLE

INDEPENDENT LIVING (As appropriate)

MEASURABLE POSTSECONDARY GOAL:

COURSES OF STUDY:		NUMBERS OF ANNUAL GOAL(S)	
TRANSITION SERVICE/ACTIVITY	PROJECTED BEGINNING DATE	ANTICIPATED DURATION	PERSON/AGENCY RESPONSIBLE

Target date for child to Graduate:

6 MEASURABLE ANNUAL GOALS

NUMBER: AREA: _____

PRESENT LEVEL OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

MEASURABLE ANNUAL GOAL METHOD(S)

METHOD FOR MEASURING THE CHILD'S PROGRESS TOWARDS ANNUAL GOAL

a. Curriculum Based Assessment	e. Short-Cycle Assessments	i. Work Samples
b. Portfolios	f. Performance Assessments	j. Inventories
c. Observation	g. Checklists	k. Rubrics
d. Anecdotal Records	h. Running Records	

MEASURABLE OBJECTIVES

NUM	OBJECTIVE
.1	
.2	
.3	
.4	
.5	
.6	

METHOD AND FREQUENCY FOR REPORTING THE CHILD'S PROGRESS TO PARENTS

Written report

Email Reported every ☐ weeks

Phone call

Journal entry

The child's progress will be reported to the child's parents each time report cards are issued

Other _____

Note: Progress Reports must be provided to parents of a child with a disability at least as often as report cards are issued to all children. If the district provides interim reports to all children, progress reports must be provided to all parents of a child with a disability.

6 MEASURABLE ANNUAL GOALS

NUMBER: AREA: _____

PRESENT LEVEL OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

MEASURABLE ANNUAL GOAL METHOD(S)

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g. Checklists
h. Running Records
i. Work Samples
j. Inventories
k. Rubrics

MEASURABLE BENCHMARKS

NUM	BENCHMARK	DATE OF MASTERY
.1		
.2		
.3		
.4		
.5		

METHOD AND FREQUENCY FOR REPORTING THE CHILD'S PROGRESS TO PARENTS

Written report
Email
Phone call
Journal entry

Reported every ☐ weeks

The child's progress will be reported to the child's parents each time report cards are issued

Other _____

Note: Interim Progress Reports must be provided to parents of a child with a disability at least as often as report cards are issued to all children. If the district provides interim reports to all children, progress reports must be provided to all parents of a child with a disability.

7 DESCRIPTION(S) OF SPECIALLY DESIGNED SERVICES

TYPE OF SERVICE		GOAL(s) ADDRESSED	PROVIDER TITLE	LOCATION OF SERVICES
SPECIALLY DESIGNED INSTRUCTION:				
BEGIN:	END:	AMOUNT OF TIME:		FREQUENCY:
BEGIN:	END:	AMOUNT OF TIME:		FREQUENCY:
BEGIN:	END:	AMOUNT OF TIME:		FREQUENCY:
RELATED SERVICES:				
BEGIN:	END:	AMOUNT OF TIME:		FREQUENCY:
BEGIN:	END:	AMOUNT OF TIME:		FREQUENCY:
BEGIN:	END:	AMOUNT OF TIME:		FREQUENCY:
ASSISTIVE TECHNOLOGY:				
BEGIN:	END:	AMOUNT OF TIME:		FREQUENCY:
BEGIN:	END:	AMOUNT OF TIME:		FREQUENCY:
ACCOMMODATIONS:				
BEGIN:	END:	*AMOUNT OF TIME:		*FREQUENCY:

BEGIN:	END:	*AMOUNT OF TIME:		*FREQUENCY:
MODIFICATIONS:				
BEGIN:	END:	*AMOUNT OF TIME:		*FREQUENCY:
BEGIN:	END:	*AMOUNT OF TIME:		*FREQUENCY:
SUPPORT FOR SCHOOL PERSONNEL:				
BEGIN:	END:	*AMOUNT OF TIME:		**FREQUENCY:
BEGIN:	END:	*AMOUNT OF TIME:		**FREQUENCY:
SERVICE(S) TO SUPPORT MEDICAL NEEDS:				
BEGIN:	END:	*AMOUNT OF TIME:		FREQUENCY:
BEGIN:	END:	*AMOUNT OF TIME:		FREQUENCY:

KEY: *OPTIONAL ENTRY **NOT REQUIRED

8 TRANSPORTATION AS A RELATED SERVICE

Does the child have needs related to their identified disability that require special transportation? YES NO

Does the child need accommodations or modifications for transportation? YES NO

If yes, check any transportation accommodations/modifications that are needed.

The bus driver will be notified of the child's behavioral and/or medical concerns

Specially Adapted Vehicle Wheelchair lift Bus Aide

Securement Systems Car Seat Harness

Other Specify: _____

Does the child need transportation to and from provider services? YES NO

9 NONACADEMIC AND EXTRACURRICULAR ACTIVITIES

In what ways will the child have the opportunity to participate in nonacademic/extracurricular activities with his/her nondisabled peers?

Describe

If the child will not participate in non-academic/extracurricular activities, explain.

10 GENERAL FACTORS

HAS THE IEP TEAM CONSIDERED:

The strengths of the child?	YES	NO
The concerns of the parents for the education of the child?	YES	NO
The results of the initial or most recent evaluations of the child?	YES	NO
As appropriate, the results of performance on any state or district-wide assessments?	YES	NO
The academic, developmental, and functional needs of the child?	YES	NO

The need for extended school year (ESY) services

The team has determined that ESY services are not necessary.

The team has determined that ESY services are necessary for the following Goals and Objectives or Benchmarks: _____

The team needs to collect further data before making a determination and will meet again by: _____

11 LEAST RESTRICTIVE ENVIRONMENT

Does this child attend the school (or for a preschool-age child, participate in the environment) he/she would attend if not disabled? YES NO

If no, justify:

Does this child receive all special education services with nondisabled peers? YES NO

If no, justify (justification may not be solely because of needed modifications in the general curriculum):

12 STATEWIDE AND DISTRICT WIDE TESTING

For each subject tested in the child's grade, choose the method of assessment below. If "With Accommodations" is chosen for any subject, provide a description of the Accommodations for each subject in the right column.
Alternate Assessment, if chosen, must apply to all tests taken.

Will the child participate in classroom, district wide and state wide assessments with accommodations? YES NO

AREA	GRADE	CHILDREN WILL BE TESTED:	DETAIL OF ACCOMMODATIONS
READING		WITH ACCOMMODATIONS MODIFIED ASSESSMENT	
WRITING		WITH ACCOMMODATIONS MODIFIED ASSESSMENT	
MATH		WITH ACCOMMODATIONS MODIFIED ASSESSMENT	
SCIENCE		WITH ACCOMMODATIONS MODIFIED ASSESSMENT	
SOCIAL STUDIES		WITH ACCOMMODATIONS MODIFIED ASSESSMENT	
OTHER		WITH ACCOMMODATIONS MODIFIED ASSESSMENT	

Is the child to be excused from the consequences of not passing the Ohio Graduation Test (OGT)? YES NO

The child is completing a curriculum that is significantly different than the curriculum completed by other children required to take the test. YES NO

The child requires accommodations that are beyond the accommodations allowed for children taking state wide assessments. YES NO

The child is excused from the consequences of not passing the OGT in the following subjects:

Reading

Mathematics

Writing

Social Studies

Science

Met Testing Participation Requirement? Date complete: YES NO

Is the child participating in alternate assessment? YES NO

Justify the choice of alternate assessment and address why it is appropriate:

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CHILD'S NAME:

13 MEETING PARTICIPANTS

THIS IEP MEETING WAS:

Face-to-Face Meeting

Video Conference

Telephone Conference/Conference Call

Other

IEP EFFECTIVE DATES

START: _____

END: _____

DATE OF NEXT IEP REVIEW: _____

IEP MEETING PARTICIPANTS

THE FOLLOWING PEOPLE ATTENDED AND PARTICIPATED IN THE MEETING TO DEVELOP THIS IEP

POSITION	NAME	SIGNATURE
Student*		
Parent		
Parent		
District Representative*		
Intervention Specialist*		
General Education Teacher*		

PEOPLE NOT IN ATTENDANCE WHO PROVIDED INFORMATION AND RECOMMENDATIONS

POSITION	NAME	SIGNATURE	DATE

IF THE REGULAR EDUCATION TEACHER, INTERVENTION SPECIALIST, DISTRICT REPRESENTATIVE OR PERSON KNOWLEDGABLE ABOUT THE INSTRUCTIONAL IMPLICATIONS OF THE EVALUATION DATA HAVE SIGNED AS NOT IN ATTENDANCE AT THE IEP MEETING, A WRITTEN EXCUSE MUST BE ON FILE*.

14 SIGNATURES

INITIAL IEP

I give consent to initiate special education and related services specified in this IEP.*

I give consent to initiate special education and related services specified in this IEP except for **

AREA: _____

I do not give consent for special education and related services at this time.**

PARENTS' SIGNATURE: _____ DATE: _____

ANNUAL REVIEW/REVIEW OTHER THAN ANNUAL REVIEW (Not a Change of Placement)

I agree with the implementation of this IEP.*

I am signing to show my attendance/participation at the IEP team meeting but I do not agree with the following special education and related services specified in this IEP.**

AREA: _____

Note: Not a Change of Placement does NOT require a parents' signature to implement the IEP.

PARENTS' SIGNATURE: _____ DATE: _____

ANNUAL REVIEW/REVIEW OTHER THAN ANNUAL REVIEW (Change of Placement)

I give consent for the change of placement as identified in this IEP.*

I do not give consent for the change of placement as identified in this IEP.**

I revoke consent for all special education and related services.**

PARENTS' SIGNATURE: _____ DATE: _____

* This IEP serves as prior written notice if there is agreement.
**If there is not agreement or consent is revoked, the district must provide prior written notice to the parents.

TRANSFER OF RIGHTS AT MAJORITY

By the child's 17th birthday, the child and the child's parents or surrogate parent received a copy of their procedural safeguards notice and notice of the transfer of procedural safeguard rights under IDEA will take place on the child's 18th birthday. YES NO

CHILD'S SIGNATURE: _____ DATE: _____

PARENTS' SIGNATURE: _____ DATE: _____

PROCEDURAL SAFEGUARDS NOTICE

A copy of the Procedural Safeguards Notice was given to the parents at the IEP Meeting. YES NO

IF NO, DATE SENT TO PARENTS: _____

COPY OF THE IEP

A copy of the IEP was given to the parents at the IEP meeting. YES NO

IF NO, DATE SENT TO PARENTS: _____

IEP Individualized Education Program

CHILD'S NAME:

15 CHILDREN WITH VISUAL IMPAIRMENTS

This form shall be completed during the IEP meeting for each child who has a visual impairment, as defined by Ohio's Amended Substitute House Bill Number 164, which requires a statement specifying one or more reading and writing media in which instruction is appropriate to meet the child's educational needs**. A copy of this completed form is part of, and must be attached to, the child's IEP form.**

1.Annual assessment of reading and writing skills was conducted with each child in all media considered appropriate. The results of these assessments are included in "Present Levels of Development/Functioning/Performance" on the IEP and indicate both strengths and weaknesses.	YES	NO
2.The IEP contains a requirement for instruction in Braille reading and writing when that medium is appropriate and is indicated by adding "Standard English Braille" as a special service in Step 4, listing the date initiated and the anticipated duration of services.	YES	NO
3.Instruction in Braille reading and writing was carefully considered for this child and pertinent literature describing the educational benefits of instruction in Braille reading and writing was reviewed by the persons developing this child's IEP.	YES	NO
4.The following visual condition(s) was taken into account and discussed in making the above decision:	YES	NO
Condition is degenerative and progressive loss is expected.	YES	NO
Condition is currently unpredictable in nature and will be reviewed if change in visual condition is noted.	YES	NO
Condition is temporary and expected to improve.	YES	NO
Condition is stable and will be monitored.	YES	NO
5.Indicate the appropriate instructional media		
Standard English Braille	YES	NO
Large Print	YES	NO
Regular Print	YES	NO
Tape/auditory	YES	NO
Pre-reader	YES	NO
6.Complete if Braille reading and writing **ARE** appropriate at this time		
Annual goals provided	YES	NO
Short-term objectives provided	YES	NO
Date of initiation indicated	YES	NO
Frequency and duration of instructional sessions indicated	YES	NO
Level of competency to be achieved annually indicated	YES	NO
Objective determinants used to measure achievement provided	YES	NO
7.Reasons Braille reading and writing **ARE NOT** appropriate this time		
Documented visual acuity allowing the choice of larger type/regular type	YES	NO
Child is considered a pre-reader	YES	NO
Other	YES	NO