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

MEASURABLE OBJECTIVES

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

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: 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)

METHOD FOR MEASURING THE CHILD'S PROGRESS TOWARDS ANNUAL GOAL

a. Curriculum Based Assessment
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f. Performance Assessments
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:

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 ☐