



# Evaluation Report

## STUDENT INFORMATION

Student Name	Initials	Birthdate	Age	Gender M F	Grade	Today's Date
District/School	Initial Referral Date				Initial Evaluation <input type="checkbox"/>	
	Next Comprehensive Reevaluation Due				Reevaluation <input type="checkbox"/>	
Parent(s)' Name	Parent(s)' Address				Home Phone	
	E-mail				Work Phone/Cell Phone	

## EVALUATIONS AND INFORMATION PROVIDED BY THE PARENT(S) AND/OR STUDENT

Parent Comments\*: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Student Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Implications for Educational Planning: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## ASSESSMENT AREAS

Assessment results, including implications for educational planning, may be summarized or attached as written reports.

Summarized Attached

- |                          |                          |                                |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Academic Achievement           |
| <input type="checkbox"/> | <input type="checkbox"/> | Assistive Technology/Services  |
| <input type="checkbox"/> | <input type="checkbox"/> | Behavioral                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Classroom-Based Assessment*    |
| <input type="checkbox"/> | <input type="checkbox"/> | Communication                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Developmental                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Functional Behavior Assessment |

Summarized Attached

- |                          |                          |                  |
|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Observations*    |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical         |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychological    |
| <input type="checkbox"/> | <input type="checkbox"/> | Social/Emotional |
| <input type="checkbox"/> | <input type="checkbox"/> | Transition       |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____     |

\* Required

Student Name: \_\_\_\_\_

Evaluation Report Date: \_\_\_\_\_

### ASSESSMENT SUMMARIES

Assessment Area: \_\_\_\_\_

Evaluator(s): \_\_\_\_\_

Date of Eval/Observ: \_\_\_\_\_

Results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Implications for Educational Planning: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Assessment Area: \_\_\_\_\_

Evaluator(s): \_\_\_\_\_

Date of Eval/Observ: \_\_\_\_\_

Results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Implications for Educational Planning: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Assessment Area: \_\_\_\_\_

Evaluator(s): \_\_\_\_\_

Date of Eval/Observ: \_\_\_\_\_

Results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Implications for Educational Planning: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Student Name: \_\_\_\_\_

Evaluation Report Date: \_\_\_\_\_

### ASSESSMENT SUMMARIES

Assessment Area: \_\_\_\_\_

Evaluator(s): \_\_\_\_\_

Date of Eval/Observ: \_\_\_\_\_

Results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Implications for Educational Planning: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Assessment Area: \_\_\_\_\_

Evaluator(s): \_\_\_\_\_

Date of Eval/Observ: \_\_\_\_\_

Results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Implications for Educational Planning: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Assessment Area: \_\_\_\_\_

Evaluator(s): \_\_\_\_\_

Date of Eval/Observ: \_\_\_\_\_

Results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Implications for Educational Planning: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Student Name: \_\_\_\_\_

Evaluation Report Date: \_\_\_\_\_

## ELIGIBILITY DETERMINATION

Student **IS** eligible for special education and related services under the Individuals with Disabilities Education Act. Basis for making the determination that the student has a disability and needs special education and related services:

Disability criteria: \_\_\_\_\_

\_\_\_\_\_

Criteria Checklist Attached

**Why** does the student need special education and related services? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Disability Categories (check all that apply):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Autism              | <input type="checkbox"/> Deafness                           | <input type="checkbox"/> Other Health Impairment <sup>2</sup> |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Emotional Disturbance              | <input type="checkbox"/> Specific Learning Disability         |
| <input type="checkbox"/> Cognitive Delay     | <input type="checkbox"/> Hearing Impairment                 | <input type="checkbox"/> Speech Language Impairment           |
| <input type="checkbox"/> Deaf-Blindness      | <input type="checkbox"/> Orthopedic Impairment <sup>1</sup> | <input type="checkbox"/> Traumatic Brain Injury               |
|  |   | <input type="checkbox"/> Visual Impairment                    |

<sup>1</sup> Medical report required (diagnosis of orthopedic impairment by a qualified medical practitioner)

<sup>2</sup> Medical report required (medical diagnosis of chronic or acute health problem)

### Recommendations for consideration by the IEP team:

#### Special Education Services

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Adapted Physical Education | <input type="checkbox"/> Math                        | <input type="checkbox"/> Speech/Language    |
| <input type="checkbox"/> Assistive Technology       | <input type="checkbox"/> Reading                     | <input type="checkbox"/> Transition         |
| <input type="checkbox"/> Braille Instruction        | <input type="checkbox"/> Self-Help/Independence      | <input type="checkbox"/> Travel Training    |
| <input type="checkbox"/> Career/Vocational          | <input type="checkbox"/> Sensory-Motor               | <input type="checkbox"/> Written Expression |
| <input type="checkbox"/> Communication              | <input type="checkbox"/> Social/Emotional/Behavioral |   |

#### Related Services

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Assistive Technology            | <input type="checkbox"/> Orientation and Mobility       | <input type="checkbox"/> School Health/Nurse Services |
| <input type="checkbox"/> Audiology                       | <input type="checkbox"/> Parent Counseling and Training | <input type="checkbox"/> Social Work in Schools       |
| <input type="checkbox"/> Counseling                      | <input type="checkbox"/> Physical Therapy               | <input type="checkbox"/> Speech/Language              |
| <input type="checkbox"/> Early Identification/Assessment | <input type="checkbox"/> Psychological                  | <input type="checkbox"/> Therapeutic Recreation       |
| <input type="checkbox"/> Medical (diagnostic)            | <input type="checkbox"/> Recreation                     | <input type="checkbox"/> Transportation               |
| <input type="checkbox"/> Occupational Therapy            | <input type="checkbox"/> Rehabilitation Counseling      | <input type="checkbox"/> Other: _____                 |

## DOCUMENTATION—if not eligible

Student **IS NOT** eligible for special education and related services under the Individuals with Disabilities Education Act for the following reason(s):

- |  |   |
|--|---|
| <input type="checkbox"/> Does not meet disability criteria               | <input type="checkbox"/> Lack of instruction in reading or math |
| <input type="checkbox"/> Does not demonstrate need for special education | <input type="checkbox"/> Limited English proficiency            |

Discussion: \_\_\_\_\_  
\_\_\_\_\_

Recommendation for accommodation or referral for other services as appropriate: \_\_\_\_\_

The following persons, as indicated by their signatures, have participated in the development of this Evaluation Report document. The public agency shall give the parent a copy of the child's Evaluation Report document at no cost to the parent.

_____ <b>Parent</b>	_____ Date	_____ <b>Parent</b>	_____ Date
_____ <b>Student</b>	_____ Date	_____ <b>Speech/Language Pathologist</b>	_____ Date
_____ <b>Administrator or Designee</b>	_____ Date	_____ <b>Signature/Position</b>	_____ Date
_____ <b>Regular Education Teacher</b>	_____ Date	_____ <b>Signature/Position</b>	_____ Date
_____ <b>Special Education Teacher</b>	_____ Date	_____ <b>Signature/Position</b>	_____ Date
_____ <b>School Psychologist</b>	_____ Date	_____ <b>Signature/Position</b>	_____ Date

Each participant of the Evaluation Team shall be provided an opportunity to submit a separate statement of conclusions if the report does not reflect the conclusions of the participant.  Dissenting report will be attached.

Person(s) submitting a separate statement of conclusions: \_\_\_\_\_

Reasons: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### EVALUATION REPORT NOTES