

## STUDENT INFORMATION

Student's Name:		Birth Date:	Age:	Gender:	Grade:	Evaluation Date:
District / School:		Date Consent Received:		<input type="checkbox"/> Initial <input type="checkbox"/> Reevaluation		
Parent(s)'s Name:	Parent(s)'s Address:	E-mail:				
Home Phone:	Work Phone:		Cell Phone:			

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

**\*\*Parent Comments:**

**Student Comments:**

**Implications for Educational Planning:**

## ASSESSMENT SUMMARIES

Classroom Based Assessments

Assessment Area	Evaluator(s)	Date of Eval/Observ
Evaluations:		
Results:		
Implications for Educational Planning:		

Observations

Assessment Area	Evaluator(s)	Date of Eval/Observ
Evaluations:		
Results:		
Implications for Educational Planning:		

Other

Assessment Area	Evaluator(s)	Date of Eval/Observ
Evaluations:		

**ASSESSMENT SUMMARIES****Results:****Implications for Educational Planning:****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:**

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

\* Medical report required (diagnosis of orthopedic impairment by a qualified medical practitioner)

\*\* Medical report required (medical diagnosis of chronic or acute health problem)

**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"/> English Learner                        |

**Discussion:****Recommendation for accommodation or referral for other services as appropriate:****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**

**RECOMMENDATIONS FOR CONSIDERATION BY THE IEP TEAM:**

<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:

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

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

**Prior Written Notice (34 CFR 300.503)****Action(s) Proposed or Refused**

- ☐ Initiation or change in the evaluation of the student.
- ☐ Initiation or change in the identification of the student.

**Description of the specific proposed or refused action(s):**

☐ Additional Documentation attached

**Explanation of why the district proposed or refused to take the action(s):**

☐ Additional Documentation attached

**Description of each evaluation procedure, assessment, record, or report the district used as a basis for the proposal or refusal:**

☐ Additional Documentation attached

**Description of any other options the district considered and the reasons why those options were rejected:**

☐ Additional Documentation attached

**Prior Written Notice (34 CFR 300.503)****Description of other factors relevant to the district's proposal or refusal to take the action:**☐ Additional Documentation attached

As a parent of a child with a disability you have certain protections under the Procedural Safeguards of the Individuals with Disabilities Education Act (IDEA). You may obtain a copy of the pamphlet "Procedural Safeguards in Special Education" by clicking the link or by requesting a copy from the school district.

For assistance in understanding the provisions of the Individuals with Disabilities Education Act (IDEA) you may contact your child's school, the Office of Public Instruction at (406) 444-5661, or the Montana Empowerment Center at 1-877-870-1190.

**EVALUATION REPORT NOTES**