

INDIVIDUALIZED EDUCATION PROGRAM

DATES

Student Name First Middle Last DOB Age Gender

Social Security # I.D. Code Grade

Name of Parent/Surrogate/Guardian Phone: Home Phone: Work

Address Apt. # City Zip

District/School of Residence Attending District/School of Residence

Home Language Student's Language

This IEP ____ / ____ / ____

Next IEP ____ / ____ / ____

Most Recent Triennial ____ / ____ / ____

Next Triennial ____ / ____ / ____

Initial Placement in Special Ed. ____ / ____ / ____

PURPOSE OF MEETING

Initial IEP Annual Review Triennial
 Transition Other _____

AGENCY SERVICES

CA Child. Services (CCS) Dept. of Rehabilitation
 Community Mental Health Regional Center
 Dept. of Social Services Probation Dept.
 Other _____

RESIDENCY

Parent/Guardian Foster # _____
 Licensed Children's Institution # _____
 Other _____

Migrant Ed No Yes
 Limited English Proficient No Yes
 Interpreter Required No Yes

ETHNICITY

1. _____ 4. _____
 2. _____ 5. _____
 3. _____ 6. _____

PRIMARY DISABILITY

Specific Learning Disability Speech/Lang. Impaired
 Hard of Hearing Other Health Impaired
 Deaf Mental Retardation
 Deaf-Blind Multiple Disabilities
 Visually Impaired Autistic
 Orthopedically Impaired Traumatic Brain Injury
 Emotionally Disturbed Estab. Med. Disability (0-5yrs)

PRIMARY SERVICE

Considered *Recommended*

General Education
 Designated Instruction
 Resource Specialist
 Special Day Class
 Non Public School
 Other _____

PRIMARY SERVICE LOCATION

Amount of time student is outside regular classroom for special education services (K-12) _____ %
 Preschool Program Setting _____

PHYSICAL EDUCATION

General Education Specially Designed
 Modified Gen. Ed. Adapted P.E. (DIS)

OTHER PROGRAM INFORMATION

Extended School Year No Yes _____
 Differential Performance Standards for Graduation Required
 No Yes _____
 Participating in WorkAbility No Yes _____
 No Yes _____

DESIGNATED INSTRUCTION AND SERVICES

Service	Start/End Date	Frequency/Time*	Location
_____	_____ / _____	_____ / _____ (circle one)	_____
_____	_____ / _____	_____ / _____	_____
_____	_____ / _____	_____ / _____	_____
_____	_____ / _____	_____ / _____	_____

*Excluding non-student days per school calendar.

IEP SERVICES

IEP Services/Modifications will begin _____
 Duration of Services/Modifications _____

CA STATE/DISTRICT WIDE ASSESSMENTS

California General Education (STAR)
 Full Participation Partial Participation _____
 w/out Accom. w/Accomm. _____

CA Alternate Assessment
 Why? _____

CA High School Exit Exam (CAHSEE)
 Standard w/Accomm. _____

Other District Assessment? _____
 Age Exemption? Yes

PARENTAL CONSENT (Please initial areas that are acceptable)

____ I received a NOTICE OF PROCEDURAL SAFEGUARDS and understand them.
 ____ I have had the opportunity to help develop this IER
 ____ I agree with the goals and objectives of this IEP.
 ____ I agree with the placement and service recommendations.

Signature of Parent/Guardian/Surrogate/Student _____ Date _____

In addition to the parents, the following were Participants in the development of the Individualized Education Program (IEP)

Special Education Teacher/Provider _____ Date _____

General Education Teacher _____ Date _____

School District Representative _____ Date _____

Student (when appropriate) _____ Date _____

Additional Participant/Title _____ Date _____

Additional Participant/Title _____ Date _____

Additional Participant/Title _____ Date _____

Triennial Reevaluation Plan

Not due prior to next IEP review date.
 Triennial reevaluation due prior to next IEP review date. IEP team recommends that triennial evaluation be comprised of summary of progress and current educational performance.
 Other _____

Parent Signature _____ Date _____