District Procedure

☐ New Student

☒ Re-Eval

NAME:

SCHOOL: Grade: Teacher:

Please place information in order before giving to secretary for copying.

- ☐ Notice of Committee Meeting (NCM) - Original in Blue Folder
- ☐ IEP Minutes
- ☐ Environmental Form
- ☐ IEP (Individualized Education Program) - Original in Blue Folder
- ☐ Determination of/ Continuation of Eligibility Report (PPDS)
- ☐ (Parental Consent)
- ☐ Speech/Language Assessment
- ☐ Psychological Report
- ☐ Summary Report
- ☐ Internal Eligibility Checklist
- ☐ Consideration for SLD with Classroom Observation Report
- ☐ Adaptive Behavior Scales (Vineland)
- ☐ PROTOCOLS (all tests) - Originals stay in RED folder
- ☐ **S**creening Data Form (Screening Language)
- ☐ **O**rofacial Exam Checklist
- ☐ **H**earing/Vision Form
- ☐ Elementary/Secondary Teacher Narrative (**OR** Developmental History)
- ☐ Learning Style Inventory
- ☐ TEAM Form and Teacher Support Notes
- ☐ Instructional Intervention
- ☐ MET Forms
- ☐ ALL NOTICES
- ☐ Any requests to Disclose Information
- ☐ Any other information
- ☐ Summary of Parent Interview
- ☐ Copy of Birth Certificate and Social Security Card

NOTES:	Info has been entered in:
	☐ MicroSped
	☐ SEAS
	☐ MSIS
	☐ Child Find

CHILD FIND INFO		
MET Referral Date:		
MET RESPONSE: (1) Remains in Regular Ed?	Y	N
(2) Referred to TST?	Y	N
(3) Date Referred for Comprehensive Assessment:		
MET Response Date		
Parent Consent to Evaluate?	Y	N
Date of Consent:		

ELIGIBILITY DECISION		
Eligibility Decision?	Y	N
Eligibility Date:		
Parent Permission to Serve?	Y	N
IEP Date:		

MET TEAM MEMBERS PRESENT AT MEETING	
☐ Parent	☐ Agency Rep.
☐ Counselor	☐ Case Manager
☐ Psychometrist	☐ Reg. Ed. Teacher
☐ Psychologist	☐ SPED Teacher

RELATED SERVICES
☐ Speech (District)
☐ Speech (DRMC)
☐ Occupational Therapy (DRMC)
☐ Physical Therapy (DRMC)

INSTRUCTIONS	PLACEMENT	GRADUATION TRACK
☐ Make RED folder	☐ PH - Service Provider Location	☐ Regular
☐ Make BLUE folder	☐ PI - Regular Early Program	☐ Certificate
☐ Make YELLOW folder	☐ SA - Regular	☐ MS Occupational Diploma
	☐ SB - Resource	☐ District GED Option
Revised 03/12	☐ SC - Self-Contained	SCD: ☐ YES ☐ NO

Student's Name:

EVALUATION(S): Indicate plan(s) to conduct a Functional Behavioral Assessment (FBA), evaluation for Assistive Technology or other evaluation(s)/follow up(s) to determine special education and related service needs.

WRITTEN PARENTAL PERMISSION FOR INITIAL PLACEMENT

My rights and those of my child regarding procedural safeguards have been fully explained. I understand that my child has a disability and I know what that disability is; and I hereby give consent for my child to receive special education services based on his/her eligibility determination and his/her individualized education program.

Parent's Signature: **Date:**

TRANSFER OF RIGHTS

I have been informed of my rights under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA '04), Part B, as amended, that will transfer to me when I reach the age of majority.

Student's Signature: **Date:**

*** Annual IEP Meeting**

Name: _____ Special Education Teacher

Name: _____ General Education Teacher

Name: _____ Agency Representative

Name: _____ Parent(s)/Guardian

Name: _____ Student, if Applicable

Name: _____ Other

Name: _____ Other

Name: _____ Other

*** IEP Action:** ☐ **Review** ☐ **Revise** ☐ **Amend**

Name: _____ Special Education Teacher

Name: _____ General Education Teacher

Name: _____ Agency Representative

Name: _____ Parent(s)/Guardian

Name: _____ Student, if Applicable

Name: _____ Other

Name: _____ Other

Name: _____ Other

Names and positions of excused IEP Team Members (Documentation must be included in the student's file.):

Names and positions of excused IEP Team Members (Documentation must be included in the student's file.):

Date of Meeting:

Date of Meeting:

IEP meeting conducted via alternate means of technology:

☐ Video Conferencing ☐ Conference Call

☐ Other (Specify):

IEP meeting conducted via alternate means of technology:

☐ Video Conferencing ☐ Conference Call

☐ Other (Specify):

Date copy of the IEP is given to the parent/guardian:

Date copy of the IEP is given to the parent/guardian:

Projected date of Review/Revision of the IEP:

W-8

*** Does not require signatures; this section is utilized only to document individuals present at the meeting.**

RE-EVALUATION SUMMARY REPORT / ELIGIBILITY DETERMINATION

GREENVILLE PUBLIC SCHOOL DISTRICT
Dr. Janice McKinnie Monroe, Director of Special Services (662) 334-2862
430 N. Martin Luther King, Jr. Boulevard; Greenville, MS 38701

STUDENT INFORMATION

SSN: _____

Name: _____ Date of Birth: _____ Age: _____

Parent/Guardian: _____ **MSIS NO.** _____

Phone: _____ Race: _____ Sex: _____ Grade: _____

Address: _____ School: _____

The IEP Committee met to review the existing information/data (including data, information and evaluations provided by the parent(s), current curriculum/classroom-based assessment, observations by teacher(s), and if appropriate, related service provider's observations and information contained in the current IEP.

☐ **Based on the review of existing information/data, it was determined that NO ADDITIONAL DATA are needed. The attached IEP reflects the student's Present Level of Performance and educational needs in all problem areas associated with the student's disability. The data indicates the continued need for special education and/or related services as outlined on the attached IEP, and continues to support the disability of ....**

DISABILITY CATEGORY	DISABILITY CATEGORY WITH SPECIFIC SUBCATEGORY
☐ Autism	☐ **SPECIFIC LEARNING DISABILITY** ☐ Basic Reading Skills ☐ Math Calculation
☐ Deaf-Blind	☐ Listening Comprehension ☐ Reading Comprehension ☐ Math Problem Solving
☐ Developmentally Delayed	☐ Written Expression ☐ Reading Fluency ☐ Oral Expression
☐ Emotional Disability	☐ **LANGUAGE/SPEECH**
☐ Hearing Impaired	☐ Articulation ☐ Fluency ☐ Language ☐ Voice
☐ Orthopedic Impairment	☐ **INTELLECTUAL DISABILITY**
☐ Traumatic Brain Injury	☐ **IDe:** Mild (EMR) ☐ **IDt:** Moderate (TMR) ☐ **IDs:** Severe (S/PR)
☐ Visually Impaired	☐ **OTHER HEALTH IMPAIRMENT* (Describe)**
☐ **MULTIPLE DISABILITIES* (Must check 2 or more categories)**	
***Must submit separate statement presenting your conclusion.**	

(The parent is notified of the determination and the reason(s) for it, and of their right to request an assessment to determine whether the student continues to have a disability.)

☐ Parent/District requests an assessment to determine whether the student continues to have a disability. (Written Permission to Evaluate must be obtained.)

☐ Additional data are needed (specify data to be gathered): _____

☐ The additional data/information gathered supports a change in the eligibility category, as noted above. (All additional data gathered must be available for review.)

☐ Review/Revision of the IEP is needed: ☐ The revisions were made at the IEP meeting ☐ The revisions will take place at a mutually agreed upon meeting

☐ THE STUDENT NO LONGER HAS A DISABILITY AND IS NOT IN NEED OF SPECIAL EDUCATION AND/OR RELATED SERVICES. (Ensure supporting data is attached.)

Date: _____

COMMITTEE MEMBERS PRESENT:		**Agree**	**Disagree**
_____	Special Education Teacher	☐	☐
_____	Speech Pathologist	☐	☐
_____	General Education Teacher	☐	☐
_____	Case Manager	☐	☐
_____	Parent	☐	☐
_____	Agency Representative	☐	☐
_____	Psychometrist	☐	☐
_____	Other	☐	☐

Attachment T

NOTICE OF COMMITTEE MEETING

(Proposed Action to Initiate the Development or Review/Revision of IEP; Determine Behavior Plan/Interventions & Manifestation Review; Reevaluation)

_____ School District

DATE: _____ ☐ MAILED ☐ SENT ☐ GIVEN

SCHOOL: _____ NAME OF STUDENT: _____

Dear Parent:

You are invited to a meeting to discuss your child's education services and program. Any changes in your child's educational placement will also be discussed. Such services and changes in your child's program will be determined by the IEP Committee. You are considered a committee member; therefore, your participation in this meeting is needed.

We encourage you to attend this meeting as decisions will be made regarding your child's educational program. Your involvement is an important part of your child's education and your participation in this meeting is needed. The meeting will be held as follows:

TIME: _____ DATE: _____

LOCATION: _____

The purpose of the meeting is to:

- ☐ Develop a temporary IEP for your child.
- ☐ *Develop the IEP for your child, including the determination of your child's special education and related service needs
- ☐ **Discuss transition services
- ☐ Discuss options for exiting high school
- ☐ Determine your child's placement for receiving special education services
- ☐ Review and, as necessary, revise your child's IEP
- ☐ Review and, as necessary, revise your child's IEP based on the hearing officer's order to place in an interim alternate setting
- ☐ Review your child's placement for services
- ☐ Discuss reevaluation to determine whether your child continues to have a disability, including the need for special education and related services and whether your child's current disability category continues to be appropriate
- ☐ Determine placement based on disciplinary action by school authorities
- ☐ Develop and/or review a behavior plan for your child
- ☐ Develop and/or review behavioral interventions
- ☐ Determine if your child's behavior(s) is related to your child's disability
- ☐ Determine if criteria for Extended School Year (ESY) services are met.
- ☐ OTHER (Please specify): _____

Reason(s) for such action(s) proposed include requirement to:

- ☐ Determine appropriate special education and, as necessary, related services for your child
- ☐ Develop an IEP for your child so that special education and, as necessary, related services may be initiated
- ☐ Determine your child's placement to receive appropriate services
- ☐ Review and, as necessary, revise your child's IEP to ensure appropriate services are provided
- ☐ If your child is at least 14, discuss and develop/revise transition services which are a coordinated set of activities based on your child's needs that promote movement from school to post-school activities
- ☐ If your child is at least 16, discuss services from other agencies that may be available to assist with transition services
- ☐ Review program options and determine the appropriate placement for your child to receive services and, as appropriate, change your child's placement to an appropriate setting
- ☐ Review the placement of your child based on his/her educational needs
- ☐ Conduct a reevaluation due to three year mandate
- ☐ Conduct a reevaluation as requested by the parent(s) or teacher(s) or as conditions warrant
- ☐ Determine the interim alternate setting for placement based on disciplinary action by school authorities
- ☐ Change your child's placement to another setting due to disciplinary action(s)
- ☐ Develop a behavior plan or review an existing plan and revise the plan, if necessary
- ☐ Develop behavior interventions or review existing interventions and revise them, if necessary
- ☐ Determine if your child's behavior(s) is related to your child's disability
- ☐ Determine if criteria for Extended School Year (ESY) services are met.
- ☐ OTHER (Please specify): _____

Options considered before convening this meeting:

- ☐ Regular education without services
- ☐ Change in teaching methodology
- ☐ Behavior interventions
- ☐ Bilingual/ESL services
- ☐ OTHER (Please specify): _____
- ☐ Tutoring
- ☐ Schedule change
- ☐ Counseling
- ☐ Remedial Program
- ☐ Alternate Program
- ☐ Current placement with supplementary aids and services, as appropriate
- ☐ Rules and requirements mandate need for meeting

NOTICE OF COMMITTEE MEETING – Page 2
(Proposed Action to Initiate the Development or Review/Revision of IEP; Determine Behavior Plan/Interventions & Manifestation Review; Change in Placement)

The options considered were rejected by school personnel due to:

- ☐ Continued academic difficulty by your child
- ☐ Interventions were unsuccessful
- ☐ Educational needs cannot be met in current placement
- ☐ Disciplinary action(s) requirement that placement be changed in accordance with district policies
- ☐ No rejection of options; meeting must be held due to regulations and the need to review and, if necessary, revise your child's IEP

The following persons have been asked to attend this meeting (Name):

Student ☐ Yes ☐ No
Special education teacher _____
Psychologist _____
Assessment personnel _____
Speech/Language pathologist _____
Diagnostic personnel _____
School administrator _____
Behavior Specialist _____
Occupational Therapist _____
Regular education teacher _____
Vocational representative _____
Physical Therapist _____
OTHER (Please specify): _____

The following evaluation procedures, tests, records or reports will be reviewed and discussed:

- ☐ Vision/hearing screening
- ☐ Classroom observations
- ☐ Academic achievement
- ☐ Speech/language skills
- ☐ Gross/fine motor skills
- ☐ Orofacial functioning
- ☐ Visual/auditory skills
- ☐ School and/or home behaviors
- ☐ Audiological evaluations
- ☐ Functional vision assessment
- ☐ Personality assessment
- ☐ Curriculum-based assessment
- ☐ Vocational assessment
- ☐ Assistive technology assessment
- ☐ Self-help/adaptive behavior
- ☐ Functional behavioral assessment
- ☐ Cognitive functioning
- ☐ Hearing officer's decision
- ☐ Parental input
- ☐ OTHER (Please specify): _____
- ☐ Progress reports
- ☐ Current IEP
- ☐ Disciplinary action(s) by school authorities
- ☐ Requirements for high school graduation
- ☐ Program placement options
- ☐ Criteria for extended school year
- ☐ Preliminary goals & objectives for services
- ☐ State and/or district assessment program criteria

*Regulations require that written parental permission be obtained prior to the initial provision of special education and, as necessary, related services outlined on your child's IEP. After we agree on your child's initial IEP, we will want you to give us permission in writing for placement. No special education and related services will be provided to your child without your written permission.

**Your child has been invited to the meeting since one purpose of the meeting is to discuss and plan transition services. Your child's attendance is needed so we can discuss his/her preferences and interests in relation to transition services. If your child is at least 16 years old, staff from other agencies who may be able to provide appropriate services have also been invited to attend. The agencies they represent are shown below:

- ☐ Department of Vocational Rehabilitation
- ☐ Department of Mental Health
- ☐ OTHER (Please specify): _____

You may bring any individuals you believe would be of help to you due to their knowledge or expertise regarding your child.

You may contact me or any of the following resources to help you understand the federal and State regulations for educating children with disabilities and parental rights granted by those regulations:

Mississippi Department of Education	1-601-359-3498
MDE Toll Free Parent Hotline	1-877-544-0408
Mississippi Parent Training Information Center	1-800-721-7255
Disability Rights Mississippi	1-800-772-4057

Other Resources:
_____
_____

Both State and federal regulations concerning the education of children with disabilities include many parental rights and responsibilities. A copy of the procedural safeguards which include the rights available to you and your child are enclosed with this notice.

Please keep these pages for your records and complete the attached Response Form and return it to me by the noted timeframe in order to finalize the plans for the meeting. Your input and opinions concerning your child's services and placement are very important.

Sincerely,

_____ _____
Name and Title Telephone Number

NOTICE OF IEP COMMITTEE'S DECISION FOR REEVALUATION

(Additional Testing Requested)

School District: _____ Date Given: _____

Dear Parent:

The IEP Committee has reviewed existing evaluation data concerning your child _____ and determined that additional assessment data is needed to determine your child's continued eligibility to receive special education and related services or to determine your child's educational needs.

The committee's decision was based on the following reason(s):

- ☐ Previous disability category may not accurately reflect your childs disability.
- ☐ Reevaluation is necessary to determine your child's appropriate disability category.
- ☐ Evaluation is needed to determine your child's eligibility for Language/Speech services.
- ☐ Current curriculum-based assessments and observations indicate the need for additional assessment to determine your child's disability and education needs.
- ☐ The current IEP indicates a need for a reevaluation to determine your child's present level of performance, special education services and, if appropriate, the related services needs of your child.

Although the committee decided that additional assessment is needed to determine your child's disability and educational needs, your permission is necessary before any assessment can be conducted. Without your permission, district personnel cannot ensure a free appropriate public education is provided for your child. A copy of the procedural safeguards, which include the rights available to you and your child, are enclosed with this notice. An explanation of these rights has been provided to you. If you are in agreement with the committee's decision, please provide your consent for additional testing by signing the statement below.

I understand that the committee determined that additional assessment is necessary to determine my child's disability and educational needs. I have received written prior notice of the committee's decision and Procedural Safeguards. My rights and those of my child have been fully explained to me. I agree with the decision of the committee and, I hereby give my consent for additional assessment to be conducted by qualified school personnel to determine my child's particular disability category, my child's continued need for special education and, as needed, related services. I understand that my written consent for this activity is voluntary and may be revoked at any time.

_____ _____

Parent Signature Date

If you have any questions, please call _____ at _____

(Name/Title) (Phone Number)

Please return this signed notice to:

_____

(Name/Title)

_____

(Address)

NOTICE OF IEP COMMITTEE'S DECISION FOR REEVALUATION

(No Additional Assessment Needed)

School District: _____ Date Given: _____

Dear Parent:

The IEP Committee has reviewed existing evaluation data concerning your child _____ and determined that no additional assessment data is needed to determine your child's continued eligibility to receive special education and related services or to determine your child's educational needs.

The committee's decision was based on the following reason(s):

- ☐ Previous disability category accurately reflects your child's disability.
- ☐ Information provided by the parent supports the continued need for special education and, if appropriate, related services.
- ☐ Current curriculum-based assessments and observations support the current disability category and identify the education needs of your child.
- ☐ Information contained in the current IEP indicates a continued need for special education and, if appropriate, related services.

However, you, as the parent, have the right to request an assessment if you believe that additional testing is needed to determine your child's disability or educational needs. In order to document your decision, please check one of the choices below and provide your signature as indicated below.

- ☐ I understand that additional testing of my child is not necessary at this time to determine my child's disability or educational needs and I agree with this recommendation. I have received a copy of the Procedural Safeguards documents, which includes the rights available to me and my child, with this notice. An explanation of these rights has been provided to me. My signature provided below indicates I am in agreement with this recommendation.
- ☐ I do not agree with the decision that no additional assessment is needed to determine my child's disability or educational needs as documented in the manner described above, and I request that my child be reevaluated. I have received a copy of the Procedural Safeguards document, which includes the rights available to me and my child, with this notice. An explanation of these rights has been provided to me. My signature provided below is consent for additional assessment to be conducted by qualified school personnel to determine my child's particular disability category and my child's continued need for special education and related services. I understand that my written consent for this activity is voluntary and may be revoked at any time.

_____ _____

Parent Signature Date

If you have any questions, please call _____ at _____

(Name/Title) (Phone Number)

Please return this signed notice to:

_____

(Name/Title)

_____

(Address)

PARENT INVITATION TO ELIGIBILITY DETERMINATION CONFERENCE

DATE: ☐ MAILED ☐ SENT ☐ GIVEN _____

Dear Parent:

The evaluation of your child, _____, has been completed by the Multidisciplinary Team. Designated qualified professionals serving on the team will conduct a meeting to conclude the assessment information and to determine whether the data indicates your child has a disability and is in need of special education services. Your input is needed in making these decisions. You are invited to attend this meeting which has been set for:

TIME: _____ DATE: _____

LOCATION: _____

The qualified professionals from the school or district that will be in attendance include:

_____ Position

_____ Position

_____ Position

_____ Position

Your attendance and participation is encouraged as it is critical to have your input. Please plan to attend this meeting to assist in making these decisions. You may bring any individuals you believe would be of help to you due to their knowledge or expertise regarding your child.

Please complete the attached Response Form and return it to me within the noted timeframe. If you have any questions or need additional information, you may contact me at _____ .
(Telephone Number)

_____ Name and Title

_____ School/District

PARENT INVITATION RESPONSE FORM

(District Identification/Notice of Committee Meeting)

NAME OF CHILD: _____

Date Sent: _____ **Purpose of Meeting:** _____

Date of Scheduled Meeting: _____ **Time of Scheduled Meeting:** _____

Location of Scheduled Meeting: _____

Please verify your response below and return to the person listed at the bottom of the page within two (2) days.

☐ I will attend the meeting at the scheduled time.

☐ I want to come, but I cannot attend the meeting at the scheduled time. Please contact me at _____ to make other arrangements. I am available for the following:
(Telephone Number)

DATE(S)	TIME(S)
_____	_____
_____	_____
_____	_____
_____	_____

☐ I will not be able to attend the meeting in person, but would like to participate via telephone. Please contact me at _____ at the scheduled meeting time.
(Telephone Number)

☐ I do not wish to participate in the meeting. Please conduct the meeting without me being present, but contact me following the meeting.

_____ _____
Parent Signature Date

Please return this form to:

NAME AND TITLE: _____

SCHOOL: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

Method of verification _____ Date verified _____ By Whom _____

IEP COMMITTEE MEETING MINUTES

School:_____ Date:_____ Time-From_____ To:_____

Student's Name:_____

Committee Members' Signature and Position:

_____

_____

_____

_____

_____

Points of Discussion

Concerns

Recommendations

Multidisciplinary Evaluation/Eligibility Team (MEET)

Recommendations

INITIAL MEETING. **DATE:**	**Reason for Meeting:** This Initial MEET meeting is to review existing data (if any) to determine if assessment is warranted and, if so, in what areas.
INTERIM MEETING. **DATE:**	**Reason for Meeting:** This MEET meeting is held to determine if a Re-Evaluation is needed. Existing data (if any) will be reviewed to determine if assessment is warranted and, if so, in what areas.
RE-EVAL MEETING. **DATE:**	**Reason for Meeting:** This meeting is held to Re-Evaluate the student's eligibility. Current information will be discussed and reviewed at the meeting. The MEET will review existing data to determine if assessment is warranted and, if so, in what areas.
REVIEW MEETING. **DATE:**	**Reason for Meeting:** This meeting is held to review results of testing and to determine what services, if any, will be appropriate.

1 ☐ Student **does not qualify** for Special Education Services.
2 ☐ Student will be monitored because student **does not qualify** for Special Education services.
3 ☐ Student will receive further testing in speech/language.
4 ☐ Student will receive further testing in academic area(s): _____
5 ☐ Student will receive further testing in behavior: _____
6 ☐ Student will receive further testing in developmental area(s): _____
7 ☐ No further testing is warranted at this time. EXPLANATION: _____
_____
8 ☐ No IEP is needed
9 ☐ Student **qualifies** for Special Education and/or related services: _____
10 ☐ The student will receive **primary** service(s) in the area of: _____
11 ☐ The student will receive **related** service(s) in the area(s) of: _____
12 ☐ IEP was written and signed at the meeting.
13 ☐ Parent signed permission to place student in special education.
14 ☐ Parent requested a separate IEP meeting: _____

MEET MEMBERS PRESENT

_____ CHAIRPERSON / SPECIAL EDUCATION TEACHER

_____ PARENT

_____ AGENCY REPRESENTATIVE

_____ REGULAR CLASSROOM TEACHER

_____ SPEECH/LANGUAGE PATHOLOGIST

_____ PSYCHOLOGIST OR PSYCHOMETRIST

_____ MEMBER (POSITION)

_____ MEMBER (POSITION)

Name of Student: _____ School: _____

RE-EVALUATION REPORT (PAGE 1 OF 2)

Confidential Document

Name: _____ School: _____

Date of Birth: _____ Parent/Guardian: _____

Address: _____

I. Reason for Re-evaluation

- ☐ Three year reevaluation
- ☐ Prior to discontinuation of Special Education Services
- ☐ Request of Child's parent(s) or teacher(s)
- ☐ Out-of-state reevaluation
- ☐ Other (e.g., new concerns, court order, etc.) (Specify) _____

II. Documentation

Notice of Committee Meeting sent _____
Date

Re-evaluation IEP Meeting Date(s)

_____ _____

- ☐ a. No additional Assessment needed
- ☐ b. Additional Testing Required

Send Summary Of Eligibility Report and a copy of supporting documents to Diagnostic Services.

Date Next Re-evaluation Due _____

III. Review of Information Relative to: (Check if applicable)
All appropriate documentation must be maintained.

	Date of Most Current Information
☐ Previous Evaluation Report	_____
☐ Curriculum-Based Assessment	_____
☐ Functional Behavioral Assessments	_____
☐ Progress Reports/Information from Related Service	_____
(List) _____	
☐ Observation(s)	_____
☐ Eligibility Criteria of Disabilities	_____
☐ Vision Hearing Screening	_____
☐ Progress toward Meeting IEP Goals/Standards, Benchmarks/Objectives	_____
☐ Standardized Tests	_____
☐ Performance in the General Curriculum	_____
☐ Discipline Records	_____
☐ Manifestation Determinations	_____
☐ Behavior Intervention Plans	_____
☐ Transition/Vocational Data	_____
☐ Medical Information	_____
☐ Information Provided by Parent(s)	_____
☐ Other (Specify) _____	_____

Copies Must Be Provided to Teacher(s), Parent(s), and Diagnostic Services.

Confidential Document

RE-EVALUATION REPORT (PAGE 2 OF 2)

Student's Name: _____ Date of Birth: _____

IV. A. Follow-up Needed, If any:

1. ☐ Additional Data Needed/Provided: (Specify)

2. ☐ Reconvene the IEP Team after additional data collected. **This meeting MUST be scheduled so as not to exceed the due date for this re-evaluation.**

3. ☐ Other: (Specify) _____

V. Results of Re-evaluation:

B. Is there sufficient data to determine that the child/student continues to have the existing disability?
☐ YES ☐ NO

C. Is there sufficient data to determine the child/student's present levels of performance and educational needs?
☐ YES ☐ NO

Reading: _____ Math: _____ Language: _____
Present Levels of performance (Grade)

D. Is there sufficient data to determine whether the child/student continues to need special education and related services?
☐ YES ☐ NO

E. Is there sufficient data to determine whether any additions or modification to the special education and related services are needed to enable the child/student to meet the measurable annual goals set out in the Individualized Education Program (IEP) of the child/student and to participate, as appropriate, in the general curriculum?
☐ YES ☐ NO

Attach the SUMMARY OF ELIGIBILITY REPORT

Date Next Re-evaluation is Due _____

Copies of Re-evaluation Report (pages one and two), Summary of Eligibility Report, and any new Team Member Reports or data generated through the Re-evaluation must be provided to Teacher(s), Parent(s), and staff.

Update your class rolls after re-evaluation is complete.

MDE ELEMENTARY AND SECONDARY REEVALUATION TEACHER NARRATIVE

I. IDENTIFYING INFORMATION

Name of Child		Grade	School		
Sex	**Race**		**Date of Birth**	**Age of Child**	**Grades Repeated**
Irregularities in Attendance		**Native Language Spoken at Home**		**Diploma Track** ☐ Reg Dip ☐ Occ Dip ☐ Cert	
Parent's Name(s)		**Address**		**Phone Number**	

II. GENERAL

Report average academic grades in each subject or curriculum area for the current school year. Please note if subject(s) or curriculum area is taught in a special class with the grade given by the special education teacher. Please include grading scale used by the district.

Grading Scale Used By District: A=93-100 B=85-92 C=75-84 D=70-74 F=69 or below

Curriculum Area/Subject	Grade	Reg/ Sped	Curriculum Area/Subject	Grade	Reg/ Sped	Grading Scale Used by District

III. CHARACTERISTICS

Indicate whether the child has a problem in any of the designated areas. To complete this section, utilize the current IEP, mastery of skills documentation, the previous Assessment date, knowledge of the child from the parent or child, and any available reports/information on file. Information in this section will be discussed with the Assessment Team to ensure a valid and appropriate evaluation, as well as to determine the child's problem areas in Step A of the Comprehensive Assessment. When it is determined the child's only problem is Language/Speech, indicate if problems in Hearing, Orofacial, and Language/Speech areas.

AREA	PROBLEM		COMMENTS
PHYSICAL	**YES**	**NO**	
Hearing	☐	☐	
Vision	☐	☐	
Physical Condition	☐	☐	
Orofacial	☐	☐	
Gross Motor Skills	☐	☐	
Fine Motor Skills	☐	☐	

AREA	PROBLEM		COMMENTS
LANGUAGE/SPEECH	**YES**	**NO**	
Language	☐	☐	
Articulation	☐	☐	
Voice	☐	☐	
Fluency	☐	☐	

AREA	PROBLEM		COMMENTS
SOCIAL/BEHAVIORAL/ EMOTIONAL	**YES**	**NO**	
Social Skills	☐	☐	
Behavior	☐	☐	
Emotional	☐	☐	

AREA	PROBLEM		COMMENTS
EDUCATIONAL	**YES**	**NO**	
Visual Perception	☐	☐	
Auditory Perception (Including Listening Comprehension)	☐	☐	
Achievement	☐	☐	
Reading	☐	☐	
Math	☐	☐	
Written Expression	☐	☐	
Oral Expression	☐	☐	
Functional Academics	☐	☐	
Transition	☐	☐	

IV. OTHER TEACHER COMMENTS

A copy of the child's IEP, which is current at the time this Narrative is completed, must be attached, along with mastery of skills documentation, date utilized to obtain previous eligibility ruling, and any other relevant reports/information.

_____ _____

Teacher's Signature Date

HEARING/VISION SCREENING RESULTS

DI-SE-F55 Revised, August 1992

Student Name:	Age:
School:	District:

PART I

A. HEARING SCREENING

Instrument:

	1st Screening	2nd Screening
PASS		
FAIL		
EXAMINER		
DATE		

B. VISION SCREENING

Instrument:

		1st Screening		2nd Screening	
Screened wearing glasses?		YES NO	☐ ☐	YES NO	☐ ☐
Both Eyes					
Right Eye - Far Vision					
Left Eye - Far Vision					
Near Vision		PASS FAIL	☐ ☐	PASS FAIL	☐ ☐
FIRST SCREENING	EXAMINER DATE				
SECOND SCREENING	EXAMINER DATE				

PART II

If an attempt is made to condition a severely handicapped child for hearing/vision screening and no response can be obtained, then a quantitative description of the child's hearing/vision must be completed by an individual who works with the child.

A. HEARING

EXAMINER:

DATE:

	YES	NO
1. Does subject respond to noise, i.e. ringing bell, rattle, etc.?	☐	☐
2. Does subject respond to name when called?	☐	☐
3. Does subject interact verbally or with gestures?	☐	☐
4. Can subject identify body part on verbal command?	☐	☐
5. Does subject respond to simple verbal commands?	☐	☐
6. Can subject point to person or objects when asked?	☐	☐
7. Is imitation of speech present?	☐	☐
8. Does subject's eyes and/or head turn toward a voice?	☐	☐
9. Does subject react to (not necessarily stop) an activity when he hears "No! No!"?	☐	☐
10. Does subject attend to songs sung to him?	☐	☐

B. VISION

EXAMINER:

DATE:

	YES	NO
1. Does subject follow an object with eyes?	☐	☐
2. When using a pencil, crayon, paintbrush, etc., does subject follow markings with his eyes?	☐	☐
3. Does subject pick up objects from table or floor?	☐	☐
4. Does subject reach for objects when handed to him?	☐	☐
5. Does subject grasp objects unaided or without direction from teacher?	☐	☐
6. Does subject look at an object when placed before him?	☐	☐
7. Does subject look at pictures in a book?	☐	☐
8. Do eyes and head turn toward a light that is introduced?	☐	☐
9. Does subject watch own hand movements?	☐	☐
10. Does subject look at self in mirror?	☐	☐
11. Does subject use a visual searching technique when objects are placed out of sight?	☐	☐

Describe additional behaviors in hearing/vision that should be considered in assessment and educational programming:

GREENVILLE PUBLIC SCHOOL DISTRICT

HEALTH & MEDICAL DATA UPDATE FOR RE-EVALUATION

Legal Name: _____ (Last / First / M.I.)	DOB: _____
	Gender: _____
Parents:	Race: _____
Address: Phone:	Grade: _____

1 Are there any current health problems that would interfere with, or that should be considered when conducting a Re-Evaluation? NO ☐ YES ☐ (If "Yes," explain) _____

2 Are there any current health problems that would interfere with, or that should be considered when conducting a Re-Evaluation? NO ☐ YES ☐ (If "Yes," explain) _____

3 Are there any medications currently being taken? NO ☐ YES ☐ (If "Yes," explain) _____

4 Have there been any recent changes in your child's hearing and/or vision? NO ☐ YES ☐ (If "Yes," explain) _____

5 Has your child had any recent illness or accidents which required medical treatment? NO ☐ YES ☐ (If "Yes," explain) _____

Information provided by: _____

Interviewer: _____

Date of Interview: _____

Revised 04-01-10