

IEP Individualized Education Program

THIS IEP WILL BE IMPLEMENTED DURING THE REGULAR SCHOOL TERM UNLESS NOTED IN SECTION 4 EXTENDED SCHOOL YEAR SERVICES

DISTRICT: _____

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: _____

Is the child in preschool? YES NO

Will the child be 14 years old before the end of this IEP? YES NO

Is the child younger than 14 years of age but has transition and postsecondary goal information? YES NO

Is the child a ward of the state? YES NO

If yes, provide the name of the surrogate parent: _____

IEP by third birthday? (If transitioning from Part C services) YES NO

PARENT/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 TIMELINES

ETR COMPLETION DATE: _____

NEXT ETR DUE DATE: _____

IEP EFFECTIVE DATES:

START: _____

END: _____

NEXT IEP REVIEW: _____

IEP FORM STATUS

(Check when complete)

1. FUTURE PLANNING
 2. SPECIAL INSTRUCTIONAL FACTORS
 3. PROFILE
 4. EXTENDED SCHOOL YEAR SERVICES
 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. EXEMPTIONS
 14. MEETING PARTICIPANTS
 15. 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	INITIALS

IEP Individualized Education Program

DISTRICT:

NAME:

ID NUMBER:

DATE OF BIRTH:

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 to include Reading Improvement and Monitoring Plan (if applicable):

4 EXTENDED SCHOOL YEAR SERVICES

Has the team determined that ESY services are necessary? YES NO

If yes, what goals determined the need?


Will the team need to collect further data and reconvene to make a determination? YES NO

Date to Reconvene:

5 POSTSECONDARY TRANSITION

POSTSECONDARY TRAINING AND EDUCATION

MEASURABLE POSTSECONDARY GOAL:				
AGE-APPROPRIATE TRANSITION ASSESSMENT REGARDING POST SECONDARY TRAINING AND EDUCATION (indicating student's needs, strengths, preferences and interests)				
COURSES OF STUDY:			NUMBERS OF THE ANNUAL GOAL(S) Related to Transition Needs	
TRANSITION SERVICE/ACTIVITY	PROJECTED BEGINNING DATE	PROJECTED END DATE	FREQUENCY	PERSON/AGENCY RESPONSIBLE

Click  to add another activity

IEP Individualized Education Program

DISTRICT:

NAME:

ID NUMBER:

DATE OF BIRTH:

TYPE OF EVIDENCE INDICATING THE TRANSITION SERVICE HAS BEEN COMPLETED

- A. Anecdotal Record D. Rubric
 B. Checklist E. Other (list) _____
 C. Work Sample

COMPETITIVE INTEGRATED EMPLOYMENT

MEASURABLE POSTSECONDARY GOAL:				
AGE-APPROPRIATE TRANSITION ASSESSMENT REGARDING COMPETITIVE INTEGRATED EMPLOYMENT (indicating student's needs, strengths, preferences and interests)				
COURSES OF STUDY:			NUMBERS OF THE ANNUAL GOAL(S) Related to Transition Needs	
TRANSITION SERVICE/ACTIVITY	PROJECTED BEGINNING DATE	PROJECTED END DATE	FREQUENCY	PERSON/AGENCY RESPONSIBLE

Click to add another activity

TYPE OF EVIDENCE INDICATING THE TRANSITION SERVICE HAS BEEN COMPLETED

- A. Anecdotal Record D. Rubric
 B. Checklist E. Other (list) _____
 C. Work Sample

INDEPENDENT LIVING (as appropriate)

MEASURABLE POSTSECONDARY GOAL:				
AGE-APPROPRIATE TRANSITION ASSESSMENT REGARDING INDEPENDENT LIVING (indicating student's needs, strengths, preferences and interests)				
COURSES OF STUDY:			NUMBERS OF THE ANNUAL GOAL(S) Related to Transition Needs	
TRANSITION SERVICE/ACTIVITY	PROJECTED BEGINNING DATE	PROJECTED END DATE	FREQUENCY	PERSON/AGENCY RESPONSIBLE

Click to add another activity

TYPE OF EVIDENCE INDICATING THE TRANSITION SERVICE HAS BEEN COMPLETED

- A. Anecdotal Record D. Rubric
 B. Checklist E. Other (list) _____
 C. Work Sample

FREQUENCY OF WRITTEN PROGRESS REPORTING TOWARD COMPLETION OF TRANSITION SERVICES/ACTIVITIES TO THE CHILD'S PARENTS

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. See OP-6B Transition Progress Report form.

TARGET DATE FOR CHILD TO GRADUATE: _____

IEP Individualized Education Program

DISTRICT: _____

NAME: _____

ID NUMBER: _____

DATE OF BIRTH: _____



MEASURABLE ANNUAL GOALS

NUMBER: _____ AREA: _____

PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

--

MEASURABLE ANNUAL GOALS

--

METHOD(S) FOR MEASURING THE CHILD'S PROGRESS TOWARDS ANNUAL GOAL

- | | | |
|---|---|--|
| <input type="checkbox"/> A. Curriculum-Based Assessment | <input type="checkbox"/> E. Short-Cycle Assessments | <input type="checkbox"/> I. Work Samples |
| <input type="checkbox"/> B. Portfolios | <input type="checkbox"/> F. Performance Assessments | <input type="checkbox"/> J. Inventories |
| <input type="checkbox"/> C. Observation | <input type="checkbox"/> G. Checklists | <input type="checkbox"/> K. Rubrics |
| <input type="checkbox"/> D. Anecdotal Records | <input type="checkbox"/> H. Running Records | |

MEASURABLE OBJECTIVES

NUM	OBJECTIVE

FREQUENCY OF WRITTEN PROGRESS REPORTING TOWARD GOAL MASTERY TO THE CHILD'S PARENTS

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. See OP-6A Progress Report form.

Reported every _____ weeks

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DISTRICT: _____

NAME: _____

ID NUMBER: _____

DATE OF BIRTH: _____



MEASURABLE ANNUAL GOALS

NUMBER: _____ AREA: _____

PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

--

MEASURABLE ANNUAL GOALS

--

METHOD(S) FOR MEASURING THE CHILD'S PROGRESS TOWARDS ANNUAL GOAL

- | | | |
|---|---|--|
| <input type="checkbox"/> A. Curriculum-Based Assessment | <input type="checkbox"/> E. Short-Cycle Assessments | <input type="checkbox"/> I. Work Samples |
| <input type="checkbox"/> B. Portfolios | <input type="checkbox"/> F. Performance Assessments | <input type="checkbox"/> J. Inventories |
| <input type="checkbox"/> C. Observation | <input type="checkbox"/> G. Checklists | <input type="checkbox"/> K. Rubrics |
| <input type="checkbox"/> D. Anecdotal Records | <input type="checkbox"/> H. Running Records | |

MEASURABLE OBJECTIVES

NUM	OBJECTIVE

FREQUENCY OF WRITTEN PROGRESS REPORTING TOWARD GOAL MASTERY TO THE CHILD'S PARENTS

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. See OP-6A Progress Report form.

Reported every _____ weeks

IEP Individualized Education Program

DISTRICT: _____

NAME: _____

ID NUMBER: _____

DATE OF BIRTH: _____



MEASURABLE ANNUAL GOALS

NUMBER: _____ AREA: _____

PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

--

MEASURABLE ANNUAL GOALS

--

METHOD(S) FOR MEASURING THE CHILD'S PROGRESS TOWARDS ANNUAL GOAL

- | | | |
|---|---|--|
| <input type="checkbox"/> A. Curriculum-Based Assessment | <input type="checkbox"/> E. Short-Cycle Assessments | <input type="checkbox"/> I. Work Samples |
| <input type="checkbox"/> B. Portfolios | <input type="checkbox"/> F. Performance Assessments | <input type="checkbox"/> J. Inventories |
| <input type="checkbox"/> C. Observation | <input type="checkbox"/> G. Checklists | <input type="checkbox"/> K. Rubrics |
| <input type="checkbox"/> D. Anecdotal Records | <input type="checkbox"/> H. Running Records | |

MEASURABLE OBJECTIVES

NUM	OBJECTIVE

FREQUENCY OF WRITTEN PROGRESS REPORTING TOWARD GOAL MASTERY TO THE CHILD'S PARENTS

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. See OP-6A Progress Report form.

Reported every _____ weeks

Click + to add new goal

IEP Individualized Education Program

DISTRICT:

NAME:

ID NUMBER:

DATE OF BIRTH:

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DESCRIPTION(S) OF SPECIALLY DESIGNED SERVICES

TYPE OF SERVICE	GOAL ADDRESSED	PROVIDER TITLE	LOCATION OF SERVICE
SPECIALLY DESIGNED INSTRUCTION			
BEGIN:	END:	AMOUNT OF TIME:	FREQUENCY:

RELATED SERVICES			
BEGIN:	END:	AMOUNT OF TIME:	FREQUENCY:

ASSISTIVE TECHNOLOGY			
BEGIN:	END:	AMOUNT OF TIME:	FREQUENCY:

ACCOMMODATIONS			
BEGIN:	END:		

MODIFICATIONS			
BEGIN:	END:		

SUPPORT FOR SCHOOL PERSONNEL			
BEGIN:	END:		

SERVICE(S) TO SUPPORT MEDICAL NEEDS			
BEGIN:	END:		

8

TRANSPORTATION AS A RELATED SERVICE

Does the child require special transportation? YES NO

Does the child need transportation to and from services? YES NO

Does the child need accommodations or modifications for transportation YES NO

If yes, check any transportation accommodations/modifications below that the child needs:

- The bus driver will be notified of the child's behavioral and/or medical concerns Aide (for transportation only)
- Specially Adapted Vehicle Wheelchair lift Safety Vest Car Seat Securement Systems
- Other – Specify: _____

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NAME:

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DATE OF BIRTH:

9 NONACADEMIC AND EXTRACURRICULAR ACTIVITIES

In what ways will the child have the opportunity to participate in nonacademic/extracurricular activities with their 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 <input type="checkbox"/> | NO <input type="checkbox"/> | |
| The concerns of the parents for the education of the child? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| The results of the initial or most recent evaluation of the child? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| As appropriate, the results of performance on any state or district-wide assessments? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| The academic, developmental and functional needs of the child? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| Regarding the Third Grade Reading Guarantee, is the child on-track for reading? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | NA <input type="checkbox"/> |

11 LEAST RESTRICTIVE ENVIRONMENT

For School Age:

Does the child attend the school they would attend if not disabled? YES NO

If no, justify:

Does the 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 education curriculum):

For Preschool:

Does the child attend a general education setting? YES NO

Does the child receive all of his/her special education and related services embedded within regular classroom routines and activities? YES NO

What prevents the child from receiving special education and/or related services embedded with the regular classroom routines and activities?

What prevents the child from being able to attend a general education setting?

Who provides the child with instruction in the general education curriculum?

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STATEWIDE AND DISTRICT WIDE TESTING

Is the child participating in the Alternate Assessment for Students with Significant Cognitive Disabilities (AASCD)? YES NO

Click below for guidance in considering AASCD:

[Ohio's Alternate Assessment Participation Decision-Making Tool](#)

If yes, justify the choice of alternate assessment and address why it is appropriate below:

Accessibility on district and statewide tests

Will the child participate in district wide and statewide assessments with accommodations? YES NO

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.

1. DISTRICT TESTING (Note specific test or tests that student will be taking and any differences in allowable accommodations that may be test specific within the classroom across the district)

AREA	ASSESSMENT TITLE	DETAIL OF ACCOMMODATIONS
<input type="radio"/> ELA		
<input type="radio"/> Mathematics		
<input type="radio"/> Science		
<input type="radio"/> Social Studies		
<input type="radio"/> Other		

2. STATEWIDE TESTING (Note specific test or tests that student will be taking and any differences in allowable accommodations that may be test specific)

AREA	ASSESSMENT TITLE	DETAIL OF ACCOMMODATIONS
<input type="radio"/> ELA		
<input type="radio"/> Mathematics		
<input type="radio"/> Science		
<input type="radio"/> Social Studies		
<input type="radio"/> Other		

IEP Individualized Education Program

DISTRICT:

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DATE OF BIRTH:

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EXEMPTIONS

Third Grade Reading Guarantee (See [The Ohio Third Grade Reading Guarantee Guidance Manual](#) for details)

Applicable NA

Does the child have a significant cognitive disability?

YES NO

If yes, the child is not required to take the reading diagnostic assessment and is, therefore, removed from all the provisions of the Third Grade Reading Guarantee (including retention).

If no, the team considered all data and made the following decision (check one):

Not to exempt the child from the retention provision of the Third Grade Reading Guarantee

To exempt the child from the retention provision of the Third Grade Reading Guarantee

Graduation Tests

Applicable NA

Is the child excused from the consequences of not passing required graduation tests?

YES NO

The child is excused from the consequences of not passing the required graduation tests in the following subjects:

Category	Course Title	Justification

Other Assessments

Applicable NA

Assessment	Justification

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NAME:

ID NUMBER:

DATE OF BIRTH:

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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:

NAME (Print)	POSITION	SIGNATURE	DATE

PEOPLE NOT IN ATTENDANCE WHO PROVIDED INFORMATION AND RECOMMENDATIONS:

NAME (Print)	POSITION	SIGNATURE	DATE

*IF THE GENERAL EDUCATION TEACHER, INTERVENTION SPECIALIST, DISTRICT REPRESENTATIVE OR PERSON KNOWLEDGEABLE ABOUT THE INSTRUCTIONAL IMPLICATIONS OF THE EVALUATION DATA HAVE SIGNED AS NOT IN ATTENDANCE AT THE IEP MEETING, THERE MUST BE A WRITTEN EXCUSE ON FILE.

**THE STUDENT IS A PREFERRED MEMBER UP TO AGE 18 WHEN THEY BECOME A REQUIRED MEMBER UNLESS THERE IS NO TRANSFER OF GUARDIANSHIP.

IEP Individualized Education Program

DISTRICT:

NAME:

ID NUMBER:

DATE OF BIRTH:

15 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. **

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

IEP 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 parent's signature to implement the IEP.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

IEP 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. **

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

PROCEDURAL SAFEGUARDS NOTICE

The parent received a copy of the Procedural Safeguards Notice at the IEP Meeting in the following form:

_____ YES NO IF NO, DATE SENT TO PARENTS: _____

Transfer of Rights at Age of 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 informing them that the transfer of procedural safeguard rights under IDEA will take place on the child's 18th birthday.

YES NO

CHILD'S SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

COPY OF THE IEP

The parents received a copy of the IEP at the IEP meeting. YES NO IF NO, DATE SENT TO PARENTS: _____

* The district must provide prior written notice to the parents summarizing the outcome of the IEP meeting before implementing the IEP.

** If there is not agreement or consent is revoked, the district must provide prior written notice to the parents.

IEP Individualized Education Program

DISTRICT:

NAME:

ID NUMBER:

DATE OF BIRTH:

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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 Academic Achievement and Functional 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 "Unified English Braille" as a special service in Section 7. 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.
 - Condition is currently unpredictable in nature and will be reviewed if change in visual condition is noted.
 - Condition is temporary and expected to improve.
 - Condition is stable and will be monitored.
5. Indicate the appropriate instructional media
 - Unified English Braille
 - Large Print
 - Regular Print
 - Tape/auditory
 - Pre-reader
6. Complete if Braille reading and writing ARE appropriate at this time
 - Annual goals provided
 - Short-term objectives provided
 - Date of initiation indicated
 - Frequency and duration of instructional sessions indicated
 - Level of competency to be achieved annually indicated
 - Objective determinants used to measure achievement provided
7. Reasons Braille reading and writing ARE NOT appropriate this time
 - Documented visual acuity allowing the choice of larger type/regular type
 - Child is considered a pre-reader
 - Other: