DISTRICT:

**SCHOOL-AGE EVALUATION PLANNING FORM *(Required)***

DATE OF PLAN:        INITIAL EVALUATION  REEVALUATION

CHILD’S NAME:       ID NUMBER:       DATE OF BIRTH:

TEAM CHAIRPERSON:

TEAM MEMBERS:

SUSPECTED DISABILITY(IES):

|  |  |  |
| --- | --- | --- |
| **ASSESSMENT AREAS RELATED TO SUSPECTED DISABILITY(IES)** | **DATA FOR REVIEW** | **PERSON RESPONSIBLE FOR ASSESSMENT AND REPORT** |
| Information Provided by Parent |  |  |
| General Intelligence |  |  |
| Academic Skills |  |  |
| Classroom-based Evaluations and Progress in the General Curriculum |  |  |
| Data from Interventions |  |  |
| Communicative Status |  |  |
| Vision |  |  |
| Hearing |  |  |
| Social Emotional Status |  |  |
| Physical Exam/General Health |  |  |
| Gross Motor |  |  |
| Fine Motor |  |  |
| Vocational/Transition |  |  |
| Background History |  |  |
| Observations |  |  |
| Behavior Assessment |  |  |
| Adaptive Behavior |  |  |
| Braille Needs |  |  |
| Audiological Needs |  |  |
| Assistive Technology Needs |  |  |
| Other: |  |  |

The Team has taken into consideration limited English proficiency to plan this assessment

The Team has taken into consideration possible sources of racial or cultural bias in planning this assessment.

**SIGNATURES**

     

School District Representative (Name/Date) Parent/Guardian (Name/Date)

     

General Education Teacher (Name/Date) Intervention Specialist (Name/Date)