

Capistrano Unified School District
Individualized Education Program (IEP) PART I (1 of 3)

Initial Date of Sp.Ed. Placement: _____

This IEP Date: _____

STUDENT INFORMATION:

Student Name _____ Birthdate _____ Age _____ M _____ F _____ Grade _____
 Address _____ City _____ State _____ ZIP _____
 Student Residence: Home Foster LCI Other _____ Ethnicity _____
 Parent/Guardian Names: _____ Phone _____ Work _____
 District/School of Residence _____ District/School of Attendance _____
 Current Placement _____ Teacher _____ Soc.Sec.# _____
 Student's Language _____ Home Language _____ English Proficiency Level _____ Interpreter Required: yes No

1. ESTABLISHMENT OF MEETING PURPOSE/INTRODUCTION OF ATTENDEES:

Initial Meeting Review Annual Review Triennial Evaluation Program Transition Individualized Transition Plan Other _____
 Parents advised of meeting: In Person Phone Letter Date _____
 Parent/Guardian or Representative in Attendance: Yes No (If No, state action to encourage attendance _____)

2. REVIEW OF PARENT RIGHTS COMPLETED BY: _____ INITIALS OF ADMINISTRATOR/ DESIGNEE

3. REVIEW OF ASSESSMENT INFORMATION/CURRENT GOALS & OBJECTIVES/PRESENT LEVELS OF PERFORMANCE/PARENT INPUT/REGULAR ED. INPUT

4. ELIGIBILITY FOR SPECIAL EDUCATION (BASED UPON ASSESSMENT INFORMATION/REVIEWED AT INITIAL AND TRIENNIAL IEP MEETINGS)

Student not found to be eligible for special education services, If not eligible for 504 services? No Yes - Refer to 504 Team Yes - Refer to 504 plan dated: _____
 Student eligible for Special Education under condition of.

- | | | |
|---|--|--|
| <input type="checkbox"/> Specific Learning Disability | <input type="checkbox"/> Orthopedically Impaired | <input type="checkbox"/> Deaf-Blind |
| <input type="checkbox"/> Speech and Language Impaired | <input type="checkbox"/> Visually Impaired | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Deaf/Hard of Hearing | <input type="checkbox"/> Other Health Impaired |
| <input type="checkbox"/> Limited Intellectual Functioning | <input type="checkbox"/> Emotionally Disturbed | <input type="checkbox"/> Non-categorical /Medical Condition
(ages 0-5 years only) |

Functional Description of Handicapping Condition:

5. GOALS AND OBJECTIVES DEVELOPED/REVISED (SEE PART II)

6. SERVICES CONSIDERED/RECOMMENDED

Student does not require special education services Dismiss from Special Education Continue / Modify Regular Program

Cons.	Rec.	Type of Service	• Frequency/Duration/Location	Dates of Service		Comments
				From	To	
		Regular Classroom - supplemented				
		Resource Specialist Program				
		Special Day Class				
		Non-Public School				
		State School				
		Other				
		Other				
		Designated Instruction/Services	Speech/Language			
			If no, P.E. type _____			
			Other _____			
			Other _____			

*Services provided per school calendar excluding non-student days
 Extended School Year Yes No Special Education Transportation: Yes _____ No _____
 Triennial Evaluation Date: _____
 Next IEP Review Date: _____