

**SPECIAL EDUCATION AND RELATED SERVICES**

INSTRUCTION		
Year _____ Semester _____ COURSE/CURRICULUM AREA	GENERAL ED TIME	SPECIAL ED TIME

DIRECT RELATED SERVICES	TIME PER WK OR MO
Occupational Therapy	
Physical Therapy	
Counseling	
Interpreting Services	

INSTRUCTION		
Year _____ Semester _____ COURSE/CURRICULUM AREA	GENERAL ED TIME	SPECIAL ED TIME

CONSULTATIVE RELATED SERVICES	TIME PER WK OR MO
Occupational Therapy	
Physical Therapy	
Counseling	

Extended School Year Services:  
 YES (ATTACH ESY FORM)  
 NO

YES  NO Special Transportation If YES, cite justification: \_\_\_\_\_

YES  N/A Parents of students with visual or auditory impairments or deaf-blindness have been given information about the Texas School for the Blind and Visually Impaired or Texas School for the Deaf.

**PLACEMENT DETERMINATION:** The committee determined that services will be provided at:

\_\_\_\_\_  
 NAME OF SCHOOL CAMPUS

\_\_\_\_\_  
 NAME OF INSTRUCTIONAL ARRANGEMENT

YES  NO This is the campus the student would attend if not disabled. If NO, identify the service which cannot reasonably be provided on student's home campus.

24 hour care  Structured behavior management system  Other \_\_\_\_\_

YES  NO This is the campus which is as close as possible to the student's home. If NO, justify:

Student lives in a residential treatment facility  Other \_\_\_\_\_