

KIDSS

ANW Education Cooperative
710 W. Bridge Street, P.O. Box 207
Humboldt, Kansas 66748
620-473-2257

Printed:08/25/2010

Individualized Education Plan

Legal Name: _____	KIDS ID: _____
First Parent: _____	Birthdate: _____
Phones: home: _____ mom: _____ dad: _____	Age at IEP: _____
Address: _____	Grade: _____
_____	Comp Evaluation: _____
Second Parent: _____	IEP Meeting: _____
Phones: home: _____ mom: _____ dad: _____	Initiation: _____
Other: _____	
Phones: home: _____ mom: _____ dad: _____	
Neighborhood School: _____	Attendance Building: _____

Legal First Name Legal Last Name may herein be referred to as: _____
Student's preferred name: _____

Primary Exceptionality: Pri Except **Secondary Exceptionality:** Sec Except

IEP Information Privacy Notice To General Education Staff

The classroom teacher has access to a copy of this IEP located: _____

It has been noted to the General Education Staff that this information is CONFIDENTIAL and must be treated as such in compliance with State and Federal Laws.

ANW Special Education Co-op #603 IEP Signature Page

Initial IEP Meeting

Annual IEP Meeting

IEP Revision Meeting

IEP Team Discussion

Participant's signatures who participated in the development of this IEP for: Legal Full Name (first,last)

*Denotes required signatures.

*Parent/Legal Guardian Date

School Psychologist Date

Parent/Legal Guardian Date

Speech & Language Path. Date

*Student (14 yrs up) Date

Occupational Therapist Date

*Special Education Teacher/ Transition Coor. Date

Adaptive Physical Educator Date

*General Education Teacher Date

Physical Therapist Date

*Administrator/Designee Date

Vocational Coordinator Date

School Soc. Worker/Facilitator Date

Interpreter of Eval Results Date

Agency Collaborator Date

Deaf/Principal Lang Rep. Date

Any other participants that are not listed above please sign, date and list position below:

Other participant name

Position/Title

Date

Other participant name

Position/Title

Date

Text After Signatures

If any mandatory IEP members were legally excused from all or part of the IEP team meeting, please file the appropriate form.

The parents were each given a copy of the Parent Rights.
(parent initial) _____

The parents were each given a copy of the IEP.
(parent initial) _____

NOTICE OF DESTRUCTION OF SPECIAL EDUCATION RECORDS

Special education records for each student with an exceptionality are maintained by the school district until no longer needed to provide educational services to the student. This notice is to inform you that the special education records for this student will be destroyed after five (5) years following program completion or graduation from high school, whichever occurs later, unless the student (or the student's legal guardian) has taken possession of the records prior to that time from the ANW Education Cooperative #603 at 710 Bridge St., P.O. Box 207, Humboldt, Kansas. Phone (620) 473-2257.

Progress Report

Transfer of Rights

Dear Student,

Beginning on the date you turn eighteen years of age, we will provide both you and your parents with all notices required by special education laws and regulations. All other rights accorded to parents under special education laws and regulations will be transferred to you, or, if you have a legal guardian, to the legal guardian.

Date student was informed of Transfer of Rights: _____

Date student reaches Age of Majority: _____

Student signature: _____

Date: _____

Parent/legal decision maker signature: _____

Date: _____

Post Secondary Goals

Education/Training & Employment

Upon Graduation from High School I will attend:

- On the job training
- College or University
- Career or Vocation Technical School

to be employed as: _____.

Independent & Daily Living Skills

Does this student have a need for Independent & Daily Living Skills training?

- Yes
- No

If Yes, explain:

Upon completion of High School, I will live:

Individualized Education Plan

For Students in Transition

Present Levels of Academic and Functional Performance

Health/Physical

Describe the student's health/physical strengths:

THE FOLLOWING PROMPT IS FOR USE BY OT & PT PROVIDERS ONLY

Does the student have a disability in this area? Yes No

If yes, what is it?

Give a brief description, as in "CP with upper and lower involvement"

How do this student's Health/Physical attributes affect performance and functioning in the following areas:

Fine Motor:

Gross motor:

Medical Condition:

Medical Condition Examples: "requires a feeding tube" or assistance with Toileting.

Last vision date:

Vision Screen Date

Vision results: _____

Is this student visually impaired or blind? Yes No

If yes, explain:

Was there a need for an evaluation to be conducted of the student's needs for instruction in Braille? Yes No

If yes, explain:

This date must be within the last 3 years.

Last hearing date:

Hearing Screen Date

Hearing results: _____

Does this student have a hearing impairment? Yes No

If yes, explain: _____

Does this student require an Adaptive Physical Education Plan? Yes No

If yes, explain: _____

Does this student require an Individualized Health Care Plan? Yes No
(see attachment)

Does this student have prescription medication dispensed by school medical staff during the school day? Yes No

If yes, and this occurs on a regularly scheduled basis, explain:

Using the service code "SH", add the nurse as a provider to the special Education/Related Service Screen and the Anticipated Service Chart.

DO NOT forget to add the TRANSITIONAL needs as well.

Anticipated Needs: _____

Where Addressed: _____

Parental Concerns?

Yes No

If yes, explain: _____

Individualized Health Care Plan

Please enter concise Health Care information. You have 50 lines available.

Describe the students IHCP:

Social/Emotional

Describe the student's social/emotional strengths:

Is there a disability in this area? Yes No
Has the student previously had an FBA/BIP? Yes No

How does the disability affect the student's performance and functioning and his/her ability to progress in the general education curriculum for the following area? (Describe within the sections below.)

RELATIONSHIPS WITH OTHERS (Peers, Adults):

This need will be met by:

a goal. Baseline:

accommodations and/or modifications. Describe in the Modifications/Accommodations section of the IEP.

strategies or other. Describe:

RESPONSE TO LEARNING ENVIRONMENT (STRUCTURED/UNSTRUCTURED):

This need will be met by:

goal. Baseline:

accommodations and/or modifications. Describe in the Modifications/Accommodations section of the IEP.

strategies or other. Describe:

Does this student receive outside mental health services for reasons that may affect performance in the educational/school setting?

Yes No

If yes, explain:

Text input area for explaining mental health services.

DO NOT FORGET to add TRANSITIONAL NEEDS as well.

Anticipated Needs:

Text input area for anticipated needs.

Where needs addressed:

Text input area for where needs are addressed.

Parental Concerns? Yes No

If yes, Explain:

Text input area for parental concerns.

General Intelligence

Historical: General Intelligence

Strengths:

Text input area for strengths.

Legal First Name is considered to be in the [] Intellectual Range of ability, with a Percentile Rank of (##) []. The [] was administered on (MM/DD/YYYY): []

Parental Concerns? Yes No

If Yes, explain:

Text input area for parental concerns.

Pre-Academic Readiness Skills

Describe the student's pre-academic skills strengths:

Describe concerns about skills:

Parental Concerns? Yes No

If Yes, explain:

Communication

Describe the student's communication strengths:

Briefly describe the performance of typical age peers in this area:

Are there any concerns pertaining to the student's speech/language communication skills? Yes No

Any concern listed here must be addressed somewhere in the IEP.

Was formal or informal speech/language testing administered within the past year? Yes No

If yes, list name of test(s), testing information and results:

This question is for Speech/Language Pathologist use only.
Please click save immediately to update after answering this question.

Convergent Data? Yes No

The convergent data indicated there was a significant discrepancy between students articulation and/or language skills when compared to peers. They demonstrated a need for specially designed instruction in order to communicate effectively with same age peers and adults within the general education environment. This support was not available through general education.

Is the student an English as a Second Language learner (ESL)? Yes No

If yes, explain:

Empty text box for ESL explanation.

Does this student communicate by another method that is not listed? Yes No

If yes, explain:

Empty text box for communication method explanation.

Parental Concerns? Yes No

If yes, explain:

Empty text box for parental concerns explanation.

Other

Instructional or Training Needs for Post School Goals

Please enter activities (needs) individually. Each should have a brief title, a longer description of the need, the activity to meet the need (this should be short and measurable), the provider of the activity meeting the need, and the completion date.

Examples: Visit college campus, learn time management, access tutoring in school, register for classes, participate with city parks & recreation department...

Record: 1

Title of Need: _____

Description of Need: _____

Activity to meet Need:

Provider/Payor:

Completion Date: (MM/DD/YYYY) _____

Record: 2

Title of Need: _____

Description of Need: _____

Activity to meet Need:

Provider/Payor:

Completion Date: (MM/DD/YYYY)

Record: 3

Title of Need:

Description of Need:

Activity to meet Need:

Provider/Payor:

Completion Date: (MM/DD/YYYY)

Transition Related Services

This student is engaged by outside agencies. Yes No

If yes, did the parent consent to invite outside agencies to the IEP Meeting?

Yes No

Date(MM/DD/YYYY):

Please enter activities/needs (and agencies) individually. Each should have a brief title, a longer description of the need, the activity to meet the need (this should be short and measurable), the provider of the activity meeting the need, and the completion date.
Examples: Explore city/county transportation options; Identify and visit community mental health agency; Continue with Mental Health Services or Foster Care support...

Record: 1

Title of Need:

Description of Need:

Activity to meet Need:

Provider/Payor:

Completion Date(MM/DD/YYYY):

Record: 2

Title of Need:

Description of Need:

Activity to meet Need:

Provider/Payor:

Completion Date(MM/DD/YYYY):

Record: 3

Title of Need:

Description of Need:

Activity to meet Need:

Provider/Payor:

Completion Date(MM/DD/YYYY):

Community Experience, Recreation & Leisure

Does this student need transportation to access the community? Yes No

If yes, please explain:

Please enter needs individually. Each should have a brief title, a longer description of the need, the activity to meet the need (this should be short and measurable), the provider of the activity meeting the need, and the completion date.

Examples: Learn to ride a skateboard, rollerblade, a bicycle, or other outdoor activity; Open a bank account; Register to vote; Register with Selective Service; or Investigate a volunteer program...

Record: 1

Title of Need: _____

Description of Need: _____

Activity to meet Need: _____

Provider/Payor: _____ Completion Date(MM/DD/YYYY): _____

Record: 2

Title of Need: _____

Description of Need: _____

Activity to meet Need: _____

Provider/Payor: _____ Completion Date(MM/DD/YYYY): _____

Record: 3

Title of Need: _____

Description of Need: _____

Activity to meet Need: _____

Provider/Payor: _____ Completion Date(MM/DD/YYYY): _____

Voter Registration and Selective Service

Has the student registered to vote? Yes No

If No, please explain:

If the student is MALE is he registered with Selective Service? Yes No

If he is not registered, please explain:

Preferences, Interests and Employment (Past & Present)

Students preferences, interests and employment are...

Enter Students Post-School/Adult-Living Needs Individually.

Examples: Practice completing job applications; Practice interviewing; Memorizing Social Security Number...

Record: 1

Need Title: _____

Need Description (details): _____

Activity to meet need: _____

Provider: _____ Completion Date(MM/DD/YYYY): _____

Record: 2

Need Title: _____

Need Description (details): _____

Activity to meet need: _____

Provider: _____ Completion Date(MM/DD/YYYY): _____

Record: 3

Need Title: _____

Need Description (details): _____

Activity to meet need: _____

Provider: _____ Completion Date(MM/DD/YYYY): _____

Life Skills and Independent Living

Daily living skills to consider:

- Self-Advocacy
- Advocacy/Legal Service
- Transportation
- Insurance
- Financial Assistance/Support
- Personal Management
- Obtain drivers license

Examples: Learn to operate washer & dryer; take childcare classes; Purchase & prepare food; visit community agency that provides daily living skills training...

Please enter goals/skills/needs individually. Each should have a brief title, a longer description of the need, the activity to meet the need (this should be short and measurable), the provider of the activity meeting the need, and the completion date.

Record: 1

Title of Skill/Need: _____

Description of Skill/Need: _____

Activity to meet Skill/Need: _____

Provider/Payor: _____ Completion Date(MM/DD/YYYY): _____

Record: 2

Title of Skill/Need: _____

Description of Skill/Need: _____

Activity to meet Skill/Need: _____

Provider/Payor: _____ Completion Date(MM/DD/YYYY): _____

Record: 3

Title of Skill/Need: _____

Description of Skill/Need: _____

Activity to meet Skill/Need: _____

Provider/Payor: _____ Completion Date(MM/DD/YYYY): _____

Transition Assessments and Functional Vocational Evaluation

Results of Interest inventories, SSSQ, Career Scope, Learning Styles Inventory, Career Locker and others.

Results of Transitional Assessments:

Results of Functional Vocational Evaluation:

Please enter needs and activities individually. Each should have a brief title, a longer description of the need, the activity to meet the need (this should be short and measurable), the provider of the activity meeting the need, and the completion date.

Record: 1

Title of Need: _____

Description of Need: _____

Activity to meet Need: _____

Provider/Payor: _____ Completion Date(MM/DD/YYYY): _____

Record: 2

Title of Need: _____

Description of Need: _____

Activity to meet Need: _____

Provider/Payor: _____ Completion Date(MM/DD/YYYY): _____

Record: 3

Title of Need: _____

Description of Need: _____

Activity to meet Need: _____

Provider/Payor: _____ Completion Date(MM/DD/YYYY): _____

Transition Plans must be reviewed ANNUALLY with the IEP.

This Transition Plan was reviewed on (MM/DD/YYYY): _____.

Vocational Rehabilitation

Did the IEP team determine (if student is 16 years older or greater) that this student may benefit from Kansas Rehabilitation Services (KRS) assistance?

Yes No Undetermined or N/A

If yes, parental consent will be obtained at time of application.

If no, Explain below why services are not necessary:

Course of Study

The following Course of Study has been developed as part of this IEP and Transition Plan. This Course of Study is based on the student's interests and preferences, and is contingent upon the availability of courses, enrollment factors, and other unforeseeable variables. This is a recommended Course of Study to assist in obtaining the desired post secondary outcomes. If it becomes necessary to change a class which ultimately **does** not affect the projected Post School/Adult Living Outcomes another IEP meeting is not required. Further, if the change does affect the projected Post School/Adult Living Outcomes another IEP meeting will be called to discuss the changes and gain approval.

Please move courses out of this block and into the Grade Level course blocks below.
Additional information about the student and Graduation Plan may be placed here.

Graduation Plan Data:
Courses Of Study

Record: 1

Course #	Course Title	Grade Yr Taken	Credits/Hours	Career Development	Graduation Requirement	Completed Successfully
		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Record: 2

Course #	Course Title	Grade Yr Taken	Credits/Hours	Career Development	Graduation Requirement	Completed Successfully
		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Record: 3

Course #	Course Title	Grade Yr Taken	Credits/Hours	Career Development	Graduation Requirement	Completed Successfully
		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Graduation Requirements

The student will:

- Graduate with High School Diploma.
- The student may receive Special Education services through the school year they turn 21 if they have not met the goals on their IEP.

Credits to date: _____ **Projected Graduation Date(MM/DD/YYYY):** _____

Anticipated Services to be Provided

Special Education Services (Resource Room G)

What special education, consisting of specially designed instruction, will be provided for the child? (See K.A.R. 91-40-1(jjj) for guidance.) Please include frequency, duration and location in your narrative.

NSTTAC has this written in paragraph form, so we use the following verbage under this heading:

For the remainder of the current school year...

AND

For the next school year...

These services will begin on (MM/DD/YYYY): **Initiation Date**
These services will end one year from this date or when the annual IEP is rewritten.

Historical data on Services:
Special Education Services

Related Services

Based on present levels of performance, the IEP team has determined that Related Services are not currently necessary to develop adequate adult living skills.

Supplementary Services (General Education Classroom C)

Please include related services in a NARRATIVE or PARAGRAPH FORMAT not just a frequency, location and duration. Please include description of services and how provided. Co-teaching a class in Regular/Gen Ed. Classroom goes here.

For the remainder of the current school year...

AND

For the next school year until the IEP is rewritten...

These services will begin on (MM/DD/YYYY): **Initiation Date**
These services will end one year from this date or when the annual IEP is rewritten.

Historical data on Services:
Supplementary Aids and Services

Participation with Non-Disabled Students in General Education Environment (Preschool)

Select Preschool type student will attend:

- Early Childhood Special Education Preschool Community Based Preschool

Early Childhood Special Education preschool

The student will attend an Early Childhood Special Education preschool attended by children with and without disabilities. The student will have the opportunity to interact with the other students attending the program and to participate in the general education activities. The team has determined placement in a regular community-based preschool may not provide enough direct services from qualified professionals so that the student can achieve the goals and objectives of the IEP.

Participation in District-wide Assessments

Students who receive Early Childhood services in our district do not participate in district-wide assessments.

Participation in State Assessments

Students who receive Early Childhood services in our district do not participate in State Assessments.

Anticipated Extended School Year

The IEP team has enough information to determine that Legal First Name does require extended school year services.

ESY Justification (Check one or all that document the reason for ESY):

Significant regression is anticipated if ESY services are not provided.

This data should document regression/recoupment needs. It could be data taken over summer break, winter break, spring break, etc. To qualify the amount of time needed to recoup should exceed six to eight weeks. This data should be available to the Director of Student Support Services if requested.

The nature and severity of the disability(ies) necessitate ESY to ensure the provision of FAPE so that the student can make progress toward IEP goals.

Instructional areas and/or related services are needed that are crucial in moving toward self-sufficiency and independence (such self-help skills as dressing or eating, or who need continued structure to develop behavioral control).

ESY services should only include those things from the students current IEP that meet one or more of the criteria above.

List Assistive Tech Equipment or Software the student will need to address the ESY goal/s: (Please arrange for these materials to be provided to the ESY teacher)

- 1.
2.

List all anticipated ESY services on chart below:

Anticipated ESY Start Date: End Date:

Record: 1

Special Ed/ Related Services Anticipated Location Class Anticipated Frequency min. days weeks

Record: 2

Special Ed/ Related Services Anticipated Location Class Anticipated Frequency min. days weeks

Record: 3

Special Ed/ Related Services Anticipated Location Class Anticipated Frequency min. days weeks

Behavioral Intervention Plan

Describe how the student's behavior impedes his/her learning or that of others?

Were any functional behavior assessments completed? Yes No

Describe the results of the most recent functional behavior assessment?

Does this student have a positive behavior plan? Yes No

If yes, list the positive strategies and service(s) that will be used to address the behavior:

Please include the following types of Interventions in your response:
Ecological Interventions; Positive Programming Interventions; Direct Treatment Interventions and Emergency Reactive Management Strategies

Does this plan include the use of a Seclusion Room? Yes No

Provision for Seclusion Room

The location of the Seclusion room:

The maximum length of any period of seclusion (in minutes):

The number of times during a single school day that the child may be placed in the seclusion room:

The data to be collected to determine whether seclusion room is effective:

The date for the review of data (not to exceed 45 school days)(MM/DD/YYYY):

When physical restraint is used the method of restraint will be the Mandt/CPI method. Data will be collected and later reviewed.

When the seclusion room or physical restraint is used these people will be notified: the Parent, Resource Room Teacher, School Psychologist, School Social Worker, Building Principal and Coordinator.

PARENTAL CONSENT FOR SECLUSIONARY TIME OUT USE

I/We have been shown the designated place for time-out and understand the conditions and reasons for its use.

I/We have received an explanation of the procedures to be followed and their purpose.

Goals/Benchmarks

Goal No. _____
Goal Text:

State Standard:

Baseline:

Evaluation Procedure:

Benchmark # 1 Text:

Benchmark # 2 Text:

Benchmark # 3 Text:

Benchmark # 4 Text:

Benchmark # 5 Text:

Benchmark # 6 Text:

Benchmark # 7 Text:
