ETR Evaluation Team Report

EVALUATION PLANNING FORM

School Age Disability Determination

CHILD'S NAME: _____

ID NUMBER: _____

DATE OF BIRTH: _____

TEAM CHAIRPERSON: _____

SUSPECTED DISABILITY: _____

DATE OF PLAN: _____

☐ INITIAL EVALUATION

☐ REEVALUATION

TEAM MEMBERS: _____

ASSESSMENT AREAS RELATED TO SUSPECTED DISABILITY(IES)	DATA AVAILABLE[1]	FURTHER TESTING NEEDED[2]	PERSON RESPONSIBLE FOR ASSESSMENT AND REPORT
Information Provided by Parents			
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			
Adapted Behavior			
Braille needs as determined by eye care specialist			
Audiological needs as determined by certified/ licensed audiologist			
Assistive Technology needs			
Other:			

[1]Sufficient data to determine eligibility

[2]Additional data required to determine eligibility. Check if further testing is needed

☐ 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 (Name/Date)

_____
Regular Education Teacher (Name/Date)

_____
Intervention Specialist (Name/Date)