

Assessment Plan

Student Name _____

Date of Birth ___/___/___

Date ___/___/___

Initial Annual Triennial Transition Interim Other _____

To parent/guardian of _____

Assessment Plan Date ___/___/___

LEA/District _____

School _____

Grade _____

Native Language _____

English proficiency level _____

The local educational agency (LEA)/district proposes to assess your child to determine his/her eligibility for special education services or continued eligibility and present levels of academic performance and functional achievement. Your child will be assessed in all areas of suspected disability as needed.* To meet your child's individual education needs, this assessment will consist of an evaluation in only the areas checked by LEA/district. *Tests and procedures conducted pursuant to these assessments may include, but are not limited to, classroom observations, rating scales, interviews, record review, one-on-one testing, or some other types or combination of tests.

Evaluation Area	Examiner Title
<input type="checkbox"/> Academic Achievement These assessments measure reading, arithmetic, oral and written language skills, and/or general knowledge	_____
<input type="checkbox"/> Health Health information and testing is gathered to determine how your child's health affects school performance	_____
<input type="checkbox"/> Intellectual Development These assessments measure how well your child thinks, remembers, and solves problems.	_____
<input type="checkbox"/> Language/Speech Communication Development These assessments measure your child's ability to understand and use language and speak clearly and appropriately.	_____
<input type="checkbox"/> Motor Development These assessments measure how well your child coordinates body movements in small and large muscle activities. Perceptual motor skills may also be measured.	_____
<input type="checkbox"/> Social Emotional/Behavior These assessments indicate how your child feels about him/herself, gets along with others, takes care of personal needs at home, school and in the community.	_____
<input type="checkbox"/> Adaptive Behavior These assessments indicate how your child takes care of personal needs at home, school and in the community.	_____
<input type="checkbox"/> Post-Secondary Transition These assessments provide information related to transition training, education, employment, and where appropriate, independent living skills.	_____
<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Alternative Means of Assessment (Describe alternative methods of assessing the child, if applicable) _____	_____

Parents/Guardians have protections under state and federal procedural safeguard provisions. Please refer to the enclosed NOTICE OF PROCEDURAL SAFEGUARDS for an explanation of these rights. If you would like further information about your rights or the proposed action and/or referral please contact:

Print Name of Contact _____ Position _____ Phone _____ E-mail Address _____

I consent to the assessment. I understand that the results will be kept confidential and that I will be invited to attend the IEP team meeting to discuss the results. I also understand that no special education services will be provided to my child without my written consent.

I do not consent to the proposed assessment described above.

I would like the following assessment information to be considered by the IEP team _____

Signature _____
 Parent Guardian Surrogate Adult Student

Date ___/___/___

Address _____

Phone number _____

Comments _____

NOTE: Notice of Action/Prior Written Notice attached if this is an initial evaluation

Date Received by LEA/District ___/___/___