JOHNSTON PUBLIC SCHOOLS

Special Services

STUDENT_____ **SEX** _____ **D.O.B.** _____/_____/_____

SCHOOL _____ **GRADE** _____ **TEACHER/COUNSELOR** _____

PARENT/GUARDIAN _____ **ADDRESS** _____

TELEPHONE (h) _____ (w) _____ (c) _____

RACE _____ **LANGUAGE** _____ **SASID #** _____

Evaluation Dates: **Parent Authorization** _____/_____/_____ **Eligibility Date** _____/_____/_____

PSYCHOLOGICAL	EDUCATIONAL	SOCIAL	OTHER
DATE:	DATE:	DATE:	DATE:

If the evaluations and eligibility were not completed within 60 days, the reason for the delay _____
(Indicator 11 Census #)

Please check one:[ ] Add [ ] Drop [ ] Change

		FREQUENCY/DURATION		
√	**SERVICE**	**HRS/DAY**	**DAYS/WK**	**WK/MO**
	Intensive Instruction			
	Academic Support			
	Speech/Language			
	Vision			
	Occupational Therapy			
	Physical Therapy			
	Homebound Instruction			
	Other:			

[ ] Date: _____/_____/_____ Add to caseload - School _____ Teacher _____
[ ] Date: _____/_____/_____ Drop/Terminate - School _____ Teacher _____

Transportation: [ ] Yes [ ] No

Reason for exit (check one): [ ] Moved [ ] Objective met [ ] Deceased
[ ] Revocation of parent consent [ ] Other _____
Date of exit: _____/_____/_____ [ ] Reassessment indicates services no longer needed

Dropped out
[ ] Parent's signature
[ ] Student's signature (18 or older)
[ ] Graduation
[ ] Age 21
[ ] Other: _____

Completed by:

_____ _____/_____/_____
SIGNATURE DATE