

JOHNSTON PUBLIC SCHOOLS

Special Services

DATE:

STUDENT _____	D.O.B. ____/____/____	
SCHOOL _____	GRADE _____	TEACHER/COUNSELOR _____

RECORD OF PARTICIPANTS

TEAM MEMBERS	ROLE OF TEAM MEMBERS
	Chairperson/District Representative
	Interventionist
	Parent
	General Education Teacher
	Special Education Teacher
	Student (where appropriate)
	Adaptive Physical Education Teacher
	Occupational Therapist
	Physical Therapist
	Psychologist
	Social Worker
	Speech/Language Therapist
	Other:
	Other:

Please be advised that other individuals may attend the meeting at the discretion of the parent(s) or the school department.