

GENERAL CONSIDERATION IN THE DEVELOPMENT OF THE ISP

PARENTAL VISION/EDUCATIONAL CONCERNS

STUDENT STRENGTHS

State how the disability affects the student’s involvement and progress in the general curriculum or for preschool children, as appropriate, how the disability affects the child’s participation in appropriate activities. **This should reflect the adverse effects identified in the student’s most recent evaluation and eligibility determination.**

RESULTS OF RECENT ASSESSMENT DATA/PROGRESS INFORMATION

CONSIDERATIONS OF SPECIAL FACTORS

Check the boxes to indicate if the student requires a particular device or service due to special factors.

Medication/Medical Information: _____

YES	NO			DATE	PASSED	FAILED
<input type="checkbox"/>	<input type="checkbox"/>	Glasses	Vision Screening:	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aides	Hearing Screening:	_____	_____	_____
YES	NO					
<input type="checkbox"/>	<input type="checkbox"/>	Assistive Technology Devices & Services				
<input type="checkbox"/>	<input type="checkbox"/>	Blind/Visually Impaired-Braille Instruction				
<input type="checkbox"/>	<input type="checkbox"/>	Deaf/Hearing Impaired Language/Communication Needs				
<input type="checkbox"/>	<input type="checkbox"/>	Limited English Proficiency-Language/Communication Needs				
<input type="checkbox"/>	<input type="checkbox"/>	Behavior-Positive Interventions/Supports/Strategies				
<input type="checkbox"/>	<input type="checkbox"/>	Supports for school personnel				

For boxes checked “yes”, specify device and/or services required. Include any related services indicated as part of the educational services. If a Functional Assessment or Behavioral Intervention Plan is developed, attach completed forms.