

INDIANA IEP SUMMARY SHEET (revised 8-17)

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Date of Conference \_\_\_\_\_ Limited English Proficiency: YES NO

Current Grade Level \_\_\_\_\_ Grade Level Next School Year \_\_\_\_\_

Race/Ethnicity: A. American Indian B. African American C. Asian D. White E. Multi-race  
F. Hawaiian/Pacific Islander G. Hispanic

Foster placement: Yes No If yes, please include the DCS School Notification form completed by DCS Case Manager

Open Enrollment? If yes, enter Corp. of Legal Settlement based on student's residential address:  
\_\_\_\_\_

School (as it appears in the IEP>LRE Placement>Program Info., then under Corp. of Legal

Settlement) \_\_\_\_\_ NOTE: NOT SCHOOL CORPORATION NAME

Educating School \_\_\_\_\_ Proj Educating School \_\_\_\_\_  
(Current School Year) (Next School Year)

Student attends: SAVE Plymouth Acad. The Crossing (Circle one) Shortened instructional day: YES NO

Primary Area of Disability \_\_\_\_\_

Secondary Area of Disability \_\_\_\_\_

Primary Teacher of Record \_\_\_\_\_

Secondary Teacher of Record \_\_\_\_\_

Projected Primary Teacher of Record \_\_\_\_\_  
(Next School Year)

Projected Secondary Teacher of Record \_\_\_\_\_  
(Next School Year)

Current: LRE selected \_\_\_\_\_ Gen Educ \_\_\_\_\_% Special Educ \_\_\_\_\_% (These % should be added under  
add'l descriptors in the IEP)

Projected (next school year): No Change \_\_\_\_\_ LRE selected \_\_\_\_\_ Gen Educ \_\_\_\_\_% Spec Educ \_\_\_\_\_%

Extended School Year: YES NO (If yes, completed ESY decision-making guide should be attached)

Related Services: NONE OT PT Trans Sch Based Therapy Nursing O/M Interpreter

Reeval is NOT required \_\_\_\_\_ Reeval is required \_\_\_\_\_ PLEASE DOUBLE-CHECK REEVAL STATEMENT IN IEP

ISTAR Assessment \_\_\_\_\_

Permission for Voc Rehab attached: YES \_\_\_\_\_ NO \_\_\_\_\_ Obtaining \_\_\_\_\_ (Please obtain a new  
(Date signed) consent at every ACR)

Medicaid for Health-Related Services parental permission obtained: \_\_\_\_\_ Obtaining \_\_\_\_\_  
(Date signed)

NOTE: (Medicaid consent form is required for all initials and move-in conferences) (Do not obtain for service plans)

IEP Annual Review date \_\_\_\_\_ Should be 1 full year from conference date above IF ANNUAL IS ONE  
OF THE MEETING PURPOSES.

If committee intends to reconvene prior to the next Annual Review date (Out-of-School Placement 60 day review, transition  
to a different building, kindergarten transition for PK) please enter that projected date here \_\_\_\_\_