ETR Evaluation Team Report

DISTRICT: _____

SCHOOL-AGE EVALUATION PLANNING FORM *(Required)*

DATE OF PLAN: _____ ☐ INITIAL EVALUATION ☐ REEVALUATION

CHILD'S NAME: _____ ID NUMBER: _____ DATE OF BIRTH: _____

TEAM CHAIRPERSON: _____

TEAM MEMBERS: _____

SUSPECTED DISABILITY(IES): _____

ASSESSMENT AREAS RELATED TO SUSPECTED DISABILITY(IES)	DATA FOR REVIEW	PERSON RESPONSIBLE FOR ASSESSMENT AND REPORT
Information Provided by Parent		
General Intelligence		
Academic Skills		
Classroom-based Evaluations and Progress in the General Curriculum		
Data from Interventions		
Communicative Status		
Vision		
Hearing		
Social Emotional Status		
Physical Exam/General Health		
Gross Motor		
Fine Motor		
Vocational/Transition		
Background History		
Observations		
Behavior Assessment		
Adaptive Behavior		
Braille Needs		
Audiological Needs		
Assistive Technology Needs		
Other:		

☐ The Team has taken into consideration limited English proficiency to plan this assessment

☐ The Team has taken into consideration possible sources of racial or cultural bias in planning this assessment.

SIGNATURES

_____ _____

School District Representative (Name/Date) Parent/Guardian (Name/Date)

_____ _____

General Education Teacher (Name/Date) Intervention Specialist (Name/Date)