IEP at a Glance

Student: _____

Grade: ___ **Teacher:** _____

Eligibility _____

TOS: _____

Medical

Glasses: Y N

Seizures: Y N

Allergies Y N

Meds: _____

Notes:

Supports

SLP OT PT

Assistive Technology Transportation

Behavior Plan

Y N

Notes

Strengths

Areas of Need

Parent Contact:

Name: _____

Number: _____

E-mail: _____

Other:

Suggested Interventions