**INDIVIDUAL EDUCATION PLAN – Attendance Form**

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| --- | --- | --- | --- | --- |
| **IEP Meeting Date:** |  | | **IEP Implementation Date:** |  |
|  | | | | |
| The Special Education Placement for |  | of |  | is based upon his/her IEP and consideration |
| of providing these educational and related services in the Least Restrictive Environment. | | | | |

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|  | I give permission for the district to hold the IEP meeting with or without the following team members present: |  |
| (Initial) |  |  |
|  |  |  |
|  | Although notified of the IEP meeting less than 10 days before the meeting, I agree that I am given the opportunity to participate in my child’s IEP development. |  |
| (Initial) |  |  |

**Team Members Attending IEP -- please sign directly below**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
| Signature/Case manager | Date |  | Signature/Title | Date |  | Signature/Title | Date |
|  |  |  |  |  |  |  |  |
| Signature/Title | Date |  | Signature/Title | Date |  | Signature/Title | Date |
|  |  |  |  |  |  |  |  |
| Signature/Title | Date |  | Signature/Title | Date |  | Signature/Title | Date |
|  |  |  |  |  |  |  |  |
| Signature/Title | Date |  | Signature/Title | Date |  | District Representative | Date |
|  |  |  |  |  |  | **PARENTS** - If this box is checked, my/our signature gives consent or **INITIAL** placement in the Special Education program(s) noted. | |
| Signature of Parent/Guardian | Date |  | Signature of Parent/Guardian | Date |  |

**Prior Written Notice:**

A description of the action proposed or refused by the school district or approved cooperative

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| --- |
| Click or tap here to enter text. |

The School District proposes or refuses this action for the following reasons

|  |
| --- |
| Click or tap here to enter text. |

Other options the IEP team considered and reasons why those options were rejected

|  |
| --- |
| Click or tap here to enter text. |

This action is based on the evaluation, procedure, assessment, record, or reports described below

|  |
| --- |
| Click or tap here to enter text. |

Other factors which are relevant to the school district’s proposal or refusal:

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| --- |
| Click or tap here to enter text. |

*Parents of children with disabilities have rights which are protected under procedural safeguards of the Individual with Disabilities Education Act (IDEA) and 92 NAC Rule 51 of Nebraska. If you would like a free copy of your procedural safeguards, or if you have any questions regarding this notice or your rights, you may contact any of the following resources to help you understand the federal and state laws for educating children with disabilities and parental rights granted by those laws. An explanation of your rights will be provided at no cost by any of the following organizations:*

*Nebraska Parent Training Center: 800-284-8520 or 402-346-0525 Nebraska Advocacy Services: 800-422-6091 or 402-474-3183*

**The following are proposed services for your child: (as noted)** For preschoolers, consider Continuous programming.

For school age, consider Extended Year Programming

|  |  |  |  |  |  |  |  |  |  |  |  |
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| **Initial Placement**  **Change of**  **Placement**  **Continuation** | |  | **PROGRAM PLACEMENT** |  | **Number of Days/Week** |  | **Number of Min/Day** |  | **Number of Min/Week** |  | **Number of Months** |
|  | Hearing Impaired Services |  |  |  |  |  |  |  |  |
|  | Occupational Therapy Services |  |  |  |  |  |  |  |  |
|  |  |  | Physical Therapy Services |  |  |  |  |  |  |  |  |
| **Dismissed from (Name service(s)):** | |  | Program Operated by school/agency other than child’s home district |  |  |  |  |  |  |  |  |
|  | |  | Resource (provided inside regular classroom) |  |  |  |  |  |  |  |  |
| **As of:** | |  | Resource (provided outside regular classroom) |  |  |  |  |  |  |  |  |
|  | |  | Speech Therapy Services |  |  |  |  |  |  |  |  |
| **Date** | |  | Extended School Year Services |  |  |  |  |  |  |  |  |
|  | |  | Vision Services |  |  |  |  |  |  |  |  |
| **If checked this is the final year of your child’s special education program eligibility.** | |  | Psychotherapy |  |  |  |  |  |  |  |  |
|  | If suspended, services will be provided |  |  |  |  |  |  |  |  |
|  | After suspension, services will be provided |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

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|  | **For AMENDMENTS to the IEP**  I/we have visited with our child’s case manager regarding his/her present level of performance, progress and the proposed changes to his/her IEP. At this time, I/we do not feel that a formal IEP meeting is necessary to implement these changes prior to the next annual IEP meeting. My signature indicates I/we have given consent for the district to amend my/our child’s IEP without holding an official IEP meeting. Case manager – please note amendments/changes being made to the IEP: |  |
|  | Click or tap here to enter text. |  |
|  |  |  |