

Name _____

IEP Date _____

Service Options considered (in selecting LRE, consideration is given to any harmful effect on the child or quality of services that the child needs) _____

**SUPPLEMENTARY AIDS, SERVICES & OTHER SUPPORTS FOR SCHOOL PERSONNEL,
OR FOR STUDENT OR ON BEHALF OF THE STUDENT**

Aids, Services, Program Accommodations/Modifications and/or Supports		Start/End Date	Frequency	Duration	Location
	<input type="checkbox"/> Student <input type="checkbox"/> Personnel				
	<input type="checkbox"/> Student <input type="checkbox"/> Personnel				
	<input type="checkbox"/> Student <input type="checkbox"/> Personnel				

Transportation Special Ed No Yes _____

SPECIAL EDUCATION AND RELATED SERVICES

Service			Start Date	End Date
Provider		Caseload Provider		Ind/Grp/ST
Frequency	Duration	Location		
Service			Start Date	End Date
Provider		Caseload Provider		Ind/Grp/ST
Frequency	Duration	Location		
Service			Start Date	End Date
Provider		Caseload Provider		Ind/Grp/ST
Frequency	Duration	Location		

EXTENDED SCHOOL YEAR (ESY)

Yes No

ESY Service			Start Date	End Date
Provider		Caseload Provider		Ind/Grp/ST
Frequency	Duration	Location		

Programs and services will be provided according to when student is in attendance and consistent with the district of service calendar and scheduled services, excluding holidays, vacations, and non-instructional days unless otherwise specified.