

If applicable:

Student Name _____

Child's Participation with other agencies

Head Start _____ Daycare _____ Other _____

Additional recommendations of the IEP Team: _____

F. Special Education and Related Services:

Service Code	Type of Service	Sessions Per Wk/Mo/Yr	Time Per Session	Hours Per Week	Beginning Date	Ending Date	Location of Services
01	Consultation	____/____/____	____	____/____	____/____/____	____/____/____	_____
02	Direct Special Education (Special Education Instruction and Inclusion. For Inclusion, refer to State Instruction Booklet, under "Type of Service" section.)	____/____/____	____	____/____	____/____/____	____/____/____	_____
03	Supervision (Option 8 only)	____/____/____	____	____/____	____/____/____	____/____/____	_____
Related Service(s), including Instruction from Specialized Personnel							
____	____	____/____/____	____	____/____	____/____/____	____/____/____	_____
____	____	____/____/____	____	____/____	____/____/____	____/____/____	_____
Related Service Codes:							
04 Psychological Services			08 Recreation Services		12 Vision Services		16 Ancillary-Interpreter
05 Social Work Services			09 Physical Therapy		13 Audiology Services		17 Ancillary - Other
06 Occupational Therapy			10 School Health Services		14 Other Services		18 Residential
07 Speech/Language Pathology Services			11 Counseling Services		15 Ancillary-Attendant		19 Homebound/Hospital
Total Regular Education hours per week: _____				Total Special Education hours per week: _____			