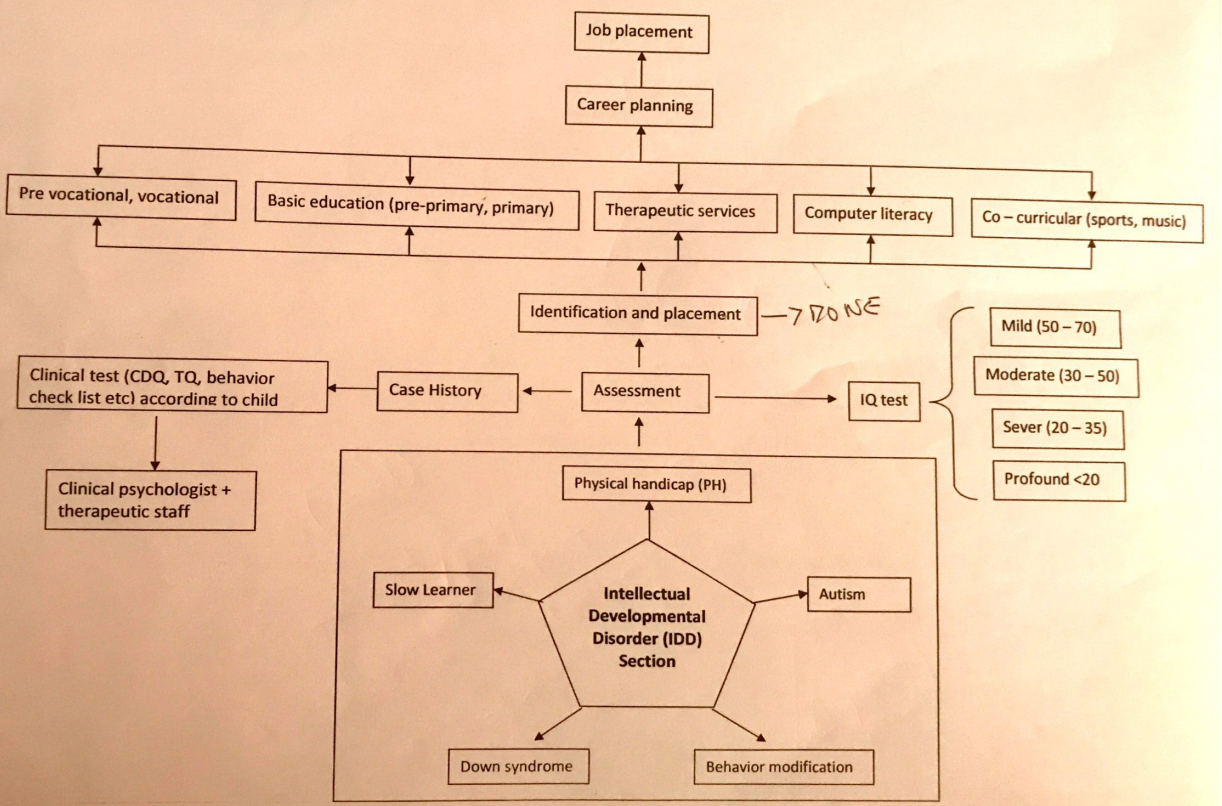

IEP

Quaid e Azam Rangers Special Children School

Individualized Educational Plan 20__-20__

I. General Information:

Child Name: _____ Father Name: _____

Age: _____ D.O.B: _____ Gender: M / F Class: _____

Parent's / Guardian phone #: _____

Diagnosis: _____

II. Meeting information:

- ☐ Initial IEP
- ☐ Annual review
- ☐ Review other than annual review
- ☐ Amendment

Language used for communicating with child: _____

III. Present Level of performance:

a. **Physical development:**

_____

_____

b. **Communication:**

_____

_____

c. **Self-help skills:**

_____

_____

d. **Cognition:**

_____

_____

e. **Socialization:**

f. **Functional academic:**

g. **Academic performance:**

h. **Pre-vocational / Vocational skills:**

i. **General / others:**

IV. Special instructional consideration:

Items checked "yes" must be addressed in this IEP:

	YES	NO
❖ Does the student exhibit behaviors which impede his/her learning or the learning of others?	☐	☐
❖ Does the student have limited English proficiency?	☐	☐
❖ Does the student require instruction in Braille and the use of Braille?	☐	☐
❖ Does the student have communication needs (deaf or hearing impaired only)?	☐	☐
❖ Does the student need assistive technology devices and/or services?	☐	☐
❖ Is the student working toward alternate achievement standards assessed via alternate assessments?	☐	☐

V. Measurable annual goals:

❖ Area: _____

Annual goal:

_____

_____

Goals	Provider	Evaluation Method	Initial date	Check date	Mastery date
	☐ Special Edu. ☐ SLP ☐ OT ☐ BT ☐ PT ☐ Others _____ _____ _____	a. Data collection			
		b. Teacher/Text test			
		c. Work samples			
		d. Classroom observation			
		e. Grades			
		f. Other: _____			

❖ Area: _____

Annual goal:

_____

_____

Goals	Provider	Evaluation Method	Initial date	Check date	Mastery date
	☐ Special Edu. ☐ SLP ☐ OT ☐ BT ☐ PT ☐ Others _____ _____ _____	g. Data collection			
		h. Teacher/Text test			
		i. Work samples			
		j. Classroom observation			
		k. Grades			
		l. Other: _____			

VI. Supplementary aids and related services:

Services/related services	Provider name	Hours per Week	Location

Aids/equipment/program modifications needed to attain annual goals:

VII. recommended instructional and/or behavioral interventions:

VIII. IEP Development Team:

S.#	NAME	Team member's signature	Position/Title