EVALUATION TEAM SUMMARY

Date: _____ ☐ New Referral ☐ Re-Evaluation

Student: _____ Gender: _____ D.O.B.: _____

ıool: _____ Grade: _____

Evaluations completed by the school district:

✓	Assessment	Date	✓	Assessment	Date
	Psychological			Other:	
	Educational			Other:	
	Social History			Rating Scales	
	Speech			Medical	
	Language			Vocational	
	Clinical Psychological			Adaptive Behavior	
	Psychiatric			Physical Therapy	
	Functional Behavioral Assessment			Occupational Therapy	

Evaluations considered from other sources:

✓	Assessment	Evaluator/Agency	Date

Based on the evaluations completed, the Evaluation Team has made the determination:

☐ The child **does not** have a disability which adversely impacts school performance and requires special education services.

☐ The child **has** a disability which adversely impacts school performance and requires special education services in the following area:

✓	Disability	✓	Disability	✓	Disability
	Autism Spectrum Disorder		Deaf-Blindness		Developmental Delay
	Emotional Disturbance		Hearing Impairment		Mental Retardation
	Multiple Disability		Orthopedic Impairment		Other Health Impaired
	Specific Learning Disability		Speech/Language		Traumatic Brain Injury
	Visual Impairment				

Participants in the decision making process:

Signature of Participants	Role	Summary Reflects My Opinion	
		Yes	No
	LEA Representative (Chairperson)		
	Parent		
	Psychologist		
	Special Educator		
	General Educator		
	Speech/Language Pathologist		
	Social Worker		