

Date Returned _____

ASSESSMENT PLAN

Initial Referral

Triennial

VENTURA COUNTY SPECIAL EDUCATION LOCAL PLAN AREA (SELPA)

Student Name _____ D.O.B. _____ C.A. _____ Grade _____ School _____ Track _____ Date _____

Address _____ Phone _____ Pupil's Language _____ EL FEP

REASON FOR ASSESSMENT/AREAS OF CONCERN

For initial referrals only

Student Referred by _____ Date Referred _____

School years interventions were provided in general education _____

The following assessments are proposed to assist in determining your child's educational needs. All assessments will be given by appropriately qualified personnel. The assessment will be in the areas checked below and may include pupil observation in a group setting, classroom work samples, district or statewide group assessments, individualized testing, teacher interview(s) and an interview with you. It also may include a review of reports you have authorized us to request or that already exist in current records. Assessments will be non-discriminatory, and alternative means of assessment may be used in situations when standardized assessments are inappropriate. Within 60 days of receipt of this signed assessment plan, an Individualized Education Program (IEP) team meeting will be held. You will be invited to attend and review assessment results and participate in determining your child's educational needs and eligibility for special education services.

PRE-ACADEMIC/ACADEMIC ACHIEVEMENT: Special Education Teacher Psychologist Other: _____

Purpose: To determine current reading, writing, and math skills or preacademic skills such as matching or sorting.

SOCIAL/EMOTIONAL BEHAVIOR: Psychologist Infant/Preschool Specialist Other: _____

Purpose: To evaluate how the student handles feelings and emotions and how he/she gets along with other people.

SELF HELP/ADAPTIVE SKILLS: Psychologist Other: _____

Purpose: To evaluate how the student functions in daily life activities.

PSYCHO-MOTOR DEVELOPMENT: Psychologist Infant/Preschool Specialist Other: _____

Purpose: To determine how well an individual coordinates body movements in both small and large muscle activities or to evaluate visual perceptual skills.

LANGUAGE/SPEECH/COMMUNICATION DEVELOPMENT: Speech-Language Pathologist Infant/Preschool Specialist Other: _____

Purpose: To determine an individual's ability to understand, relate to, and use language and speech clearly and appropriately.

INTELLECTUAL DEVELOPMENT: Psychologist Infant/Preschool Specialist Other: _____

Purpose: To determine how well individuals remember what they have seen and heard, how well they can use that information to solve problems, and to assist in predicting the student's learning rate. Verbal and performance instruments may be used as appropriate.

HEALTH ASSESSMENT: School Nurse Infant/Preschool Specialist Other: _____

Purpose: To evaluate developmental patterns and current health status as they relate to school functioning.

VOCATIONAL/PREVOCAIONAL: Special Education Teacher Psychologist Other: _____

Purpose: To determine the individual's interest and or aptitude as it relates to future job and life skill areas.

OTHER: _____

Responsible Personnel: _____

If you have any questions contact: _____

Name/Title

Date

Phone: (____) _____

PARENTAL CONSENT FOR PUPIL ASSESSMENT

I understand the purpose of the proposed Assessment Plan and have received a copy of my Parent Rights. I authorize the use of a suitable interpreter or prerecorded tests in my child's primary language as appropriate. I further understand that no individualized education program will result from this assessment without my consent. The box checked below indicates my decision.

Yes, I give my permission to conduct the assessment as described above and will make my child available for the assessment. I understand that assessment cannot begin until a copy of this form has been signed and returned.

I do do not give permission to the school district to bill the LEA Medi-Cal Billing Option Program for this assessment, if applicable. (Income from this program is used by the district to offset costs of providing special education services and will not affect your child's individual benefits.)

No, permission is denied.

Please consider the following Independent Educational Evaluation reports as part of the assessment process: _____

Please sign and return, keeping one copy for your records.

Parent/Legal Guardian/Adult Student/Person Acting as Parent (Specify) _____ Telephone Number _____ Date _____

For more information about special education and your rights contact your district special education office or visit the Ventura County SELPA website at www.venturacountyselpa.com