



Print Student's Name: _____	ID#: _____	Date: _____
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EXTENDED SCHOOL YEAR (ESY) SERVICES FORM

The following ESY services are deemed appropriate by the IEP team at a meeting held on _____. Parent(s)/guardian(s) will be notified of the location(s) and times for the delivery of school based services. (MM/DD/YY)

ESY Service Code(s)*	Specialized Instruction, Supplementary, and/or Related Services	Delivery Model Code(s)**	Duration Start - End MM/DD/YY - MM/DD/YY	Frequency ___ day(s)/week for ___ min./session; ___ time(s)/month

Additional Information: _____

The student requires the related service of transportation to access ESY services. Yes No

(If yes, include "TRS" in the above ESY service code(s) section and complete the transportation information on page 2 of this form.)

Parent Signature: _____	Student Signature: _____	Date: _____
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*** ESY Service Codes:**

ACS = Academic Goals; **AT** = Assistive Technology; **ART** = Art Therapy; **BHS** = Behavior/Social Skills; **CO** = Counseling; **FTP** = Full-Time Paraprofessional Assistance; **IDH** = Itinerant Deaf or Hard-of-Hearing Services; **IVI** = Itinerant Vision Services; **JOB** = Job Coach; **L** = Language Therapy; **MUS** = Music Therapy; **NUR** = Nursing Services; **OM** = Orientation & Mobility; **OT** = Occupational Therapy; **PE** = Specially Designed/Adapted PE; **PT** = Physical Therapy; **PTP** = Part-Time Paraprofessional Assistance; **PSY** = Psychiatric Consultation; **RBD** = Recording for the Blind & Dyslexic; **RES** = Respiratory Therapy Services; **S** = Speech Therapy; **SLI** = Sign Language Interpreter; **TRS** = Special Transportation; **OTH** = Other.

**** Delivery Model Codes:**

HPC = Home packet with consultation; **HP** = Home packet with parent supervision; **H** = home delivery; **S** = School based delivery; **OTH** = Other.



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EXTENDED SCHOOL YEAR (ESY) SERVICES FORM: TRANSPORTATION INFORMATION N/A

Parent(s)/guardian(s) will be notified of transportation pick-up and drop-off times by the transportation office. Notification of the location(s) for delivery of services will also be provided prior to the initiation of services.

Current Assigned School Name: _____ WL#: _____

Home Address: _____

If other than home address: Pick-Up: _____ Drop-Off: _____

Emergency Contact Information: _____

Additional transportation related information: _____

PRIMARY TRANSPORTATION MODE (Check one only)			
<input type="checkbox"/> Individualized Stop With Supervision	<input type="checkbox"/> Individualized Stop Without Supervision	<input type="checkbox"/> Lift Bus With Supervision	<input type="checkbox"/> Lift Bus Without Supervision
<input type="checkbox"/> Car Seat (under 40 lbs.)	<input type="checkbox"/> Safety Vest Individualized Stop With Supervision	<input type="checkbox"/> Safety Belt/Unique Seating Device Individualized Stop With Supervision	<input type="checkbox"/> Alternate Mode of Transportation May Be Required*
*Specify: _____			
SECONDARY TRANSPORTATION MODE(S) (Check all that apply)			
<input type="checkbox"/> Medically Fragile Student (Refer to Medical Consultative Review Procedures)	<input type="checkbox"/> Aide Required	<input type="checkbox"/> Medical Equipment**	<input type="checkbox"/> Shortened School Day or Alternate School Day Time(s)
<input type="checkbox"/> Student Transported Out of School District	<input type="checkbox"/> Occupational/Physical Therapy	<input type="checkbox"/> Vocational/Share Time Program	<input type="checkbox"/> Scholarship Program for Students With Disabilities
**Specify: _____			