Clear Form

Department of Exceptional Student Education

TEACHER/PHYSICAL/OCCUPATIONAL THERAPIST PRE-MEETING INPUT

(To be completed by the OT/PT with the classroom teacher)

Student Name: _____ Student ID number: _____

School Name: _____ School Work Location #: _____

Teacher Name: _____ Therapist Name: _____

An Individual Educational Plan (IEP) meeting is scheduled for: _____
Date/Time

1. Present Levels of Educational Performance (*this is to be included as part of section VI of the IEP).* The student 's strengths and abilities include: *(discuss progress on goal (s) addressed by the PT or OT).*

   The following factors affect the student's ability to access his/her education: *(PT and OT are related services that are provided when necessary to support a student's educational program).*

2. Based on the pre-conference consultation, the areas of concern within the educational environment which may require support from PT and/or OT are: *(Recommendations for PENS/ goals and adaptations to be considered by IEP team):*

Recommended Frequency PT: _____ OT: _____

_____	_____	_____	_____
Signature/Title	Date	Signature/Title	Date

Responsibility of the Classroom teacher: After the IEP meeting, please attach a copy of the completed IEP to this form and return it to PT or OT. Write in additional comments from the IEP meeting.