



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.

If there are any questions, please contact Kate Cadieux at 305 995-1830.