Student Name: ______________________ Report Date: ____________
Birth Date: __________ Grade: ______ School Building: ______________________
School District: ______________________ Parent/Guardian: ______________________

PURPOSE

This form will be used by the Evaluation Team to recommend: (Choose one)

☐ **Initial eligibility** for special education.
(Behind this page attach a copy of all referenced documents and a copy of the Consent for Initial Evaluation)

☐ **Redetermination of eligibility** for special education.
(Behind this page attach a copy of all referenced documents and the REED)

EVALUATION SUMMARY
Include enough detail to determine a starting point for instruction

Area of Evaluation	Data Source	Performance Level	Name/Date of Attached Report/Document
• Medical Information			
• Educational Performance			
• Achievement Level			
• Information from Parents			

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Student Name: **Error! Reference source not found.** DOB: **Error! Reference source not found.** Date: **Error! Reference source not found.**

DIAGNOSTIC ASSURANCE AND DOCUMENTATION

*Physician Statement received ☐ No ☐ Yes, Date ___________________

The Evaluation Team must consider the following assurance statements before making a recommendation regarding this student's eligibility:

- This student manifests limited strength, vitality, or alertness to the educational environment that (Both of the following apply):
  - The student has a chronic or acute health problem (which) ☐ Yes ☐ No
  - Adversely impacts his/her educational performance ☐ Yes ☐ No
- This student requires special education programs/services ☐ Yes ☐ No

EXCLUSIONARY CONSIDERATIONS

- Was the determinant factor for eligibility a result of:
  - Lack of instruction in reading and math? ☐ Yes ☐ No
  - Limited English proficiency? ☐ Yes ☐ No

ELIGIBILITY RECOMMENDATION

The Evaluation Team 1) finds all of the diagnostic assurance statements to be true and 2) recommends, based on the evaluation findings, that this student be determined eligible for special education programs/services under the Other Health Impairment Rule (R340.1709a). ☐ Yes ☐ No

PARTICIPANT SIGNATURES

As a member of the Evaluation Team, my input is included in writing and I agree with the eligibility recommendation: (Sign and check below. Attach more complete statement if an Evaluation Team member checks no).

	Yes	No		Yes	No
Other/Role ______________	☐	☐	Other/Role ______________	☐	☐
Other/Role ______________	☐	☐	Other/Role ______________	☐	☐
Other/Role ______________	☐	☐	Other Role ______________	☐	☐

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