

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
<ul style="list-style-type: none"> • Medical Information 			
<ul style="list-style-type: none"> • Educational Performance 			
<ul style="list-style-type: none"> • Achievement Level 			
<ul style="list-style-type: none"> • Information from Parents 			

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 an open or closed head injury resulting in impairment in one or more of the following areas: (Check all that apply)

Cognition	<input type="checkbox"/>	Language	<input type="checkbox"/>	Memory	<input type="checkbox"/>	Attention	<input type="checkbox"/>
Reasoning	<input type="checkbox"/>	Behavior	<input type="checkbox"/>	Physical Functions	<input type="checkbox"/>		
Information Processing	<input type="checkbox"/>	Speech	<input type="checkbox"/>				
- The suspected disability was caused by an external physical force resulting in an injury to the brain that adversely affects this student's educational performance due to total or partial functional disability and/or psychosocial impairment
- The suspected disability is NOT due to a brain injury that is congenital, degenerative or to brain injuries induced by birth trauma
- This student requires special education programs/services

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 Traumatic Brain Injury Rule (R340.1716). 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 _____	<input type="checkbox"/>	<input type="checkbox"/>	Other/Role _____	<input type="checkbox"/>	<input type="checkbox"/>
Other/Role _____	<input type="checkbox"/>	<input type="checkbox"/>	Other/Role _____	<input type="checkbox"/>	<input type="checkbox"/>
Other/Role _____	<input type="checkbox"/>	<input type="checkbox"/>	Other Role _____	<input type="checkbox"/>	<input type="checkbox"/>