INDIVIDUALIZED EDUCATION PROGRAM **EXTENDED SCHOOL YEAR FORM** **CONFIDENTIAL DOCUMENT**
LOUISIANA DEPARTMENT OF EDUCATION **Revised 2005**

SYSTEM____________________________STUDENT'S NAME_________________________________ID#__________________DOB______________HOMEBASED SCHOOL______________________

PRIMARY EXCEPTIONALITY____________________SECONDARY EXCEPTIONALITY___________________**ESYP SCREENING DATE**__________________ESYP MEETING DATE____________________

COMPLETE IF APPLICABLE:(Check only one.) This IEP meeting was requested by the parent. This IEP meeting was requested by school personnel.

ELIGIBILITY DETERMINED: __Regression-Recoupment __Critical Point of Instruction (**Fill in #** ____) __Self-Injurious Behavior __Employment __Transition __Excessive Absences __Late Entry __Extenuating Circumstances (Explain or Attach explanation.) __Ineligible (Explain or Attach explanation.)

NOTE: ANYTHING BELOW THIS LINE MUST BE BLANK PRIOR TO THE IEP MEETING.

IEP PARTICIPANTS	Signatures		Signatures/Position
Teacher(s)		ODR*	
		Other(s)	
Parent(s)			
Student			
			*Must be in attendance

ESYP NEEDS (Indicate the specific areas of current performance and specific needs for instruction and services during ESYP.)

Code and Objective Number	**OBJECTIVES FROM SCHOOL YEAR IEP:** WRITE: 1) objective code, 2) number, and 3) paraphrase the objective **NEW OBJECTIVES FOR ESYP** WRITE: 1) ESYP GOAL; 2) the complete objective, 3) code, and 4) number	INTEGRATION IMPORTANT Yes/No	PERSONNEL RESPONSIBLE

SETTING(S): __Regular School Campus __Special School Campus __Home __Hospital __Jobsite __Community __Other Use the number *1* to indicate the setting where the student will receive most of his/her service. Use *2, 3,* etc. to indicate whether the service is provided in other settings. The setting should reflect the location. **

DATE ESYP TO BEGIN ______ DATE ESYP TO END ________

PROGRESS REPORT(S): Progress Reports for ESYP will be sent home every ____ weeks or ____ at the end of ESYP.

I have received a copy of my Procedural Safeguards.

INSTRUCTIONAL RESOURCES NEEDED FOR ESYP	Duration	Individual/ Group	Minutes/ Session	Sessions/ Week	Location**	Primary Service Provider (title)
SPECIAL EDUCATION INSTRUCTION						
SPEECH/LANGUAGE THERAPY		I G				
ADAPTED PHYSICAL EDUCATION		I G				
		I G				
		I G				

COMMENTS

I agree to ensure that the ESY Program described in this ESY IEP is provided.

Officially Designated Represent. of Local Education Agency Date

After discussing my child's special education needs, I approve this ESY IEP.

Parent/Guardian/Surrogate Parent/Competent Major/Student Date

EVEN THOUGH MY CHILD QUALIFIES FOR ESYP SERVICES, I DECLINE THESE SERVICES

Parent/Guardian/Surrogate Parent/Competent Major/Student Date

TRANSPORTATION NEEDED: (Circle.) Yes No (Describe.)

Copies must be provided to Teacher(s), Parent(s), and Central Office.