Marion K. Salomon & Associates, Inc.
Helping Children with Developmental Delays
WWW.MKSALOMON.COM

Meeting Results

Date of Meeting: _____ [ ] EI [ ] CPSE [ ] CSE

Student: _____ D.O.B _____

County: _____ District: _____

Initial EIOD: _____ OSC: _____
(Suffolk EI Only) (EI Only)

EIOD_____ Provider: _____
(EI Only) (meeting representative)

IFSP Dates: _____(EI only) **FBA/BIP:**_____
(due by)

IEP Dates:_____(CPSE only) **Summer IEP Dates:** _____
(if applicable)

Program/School: **Class Ratio:** **Hours:** **Days/Week:**

_____ _____ _____ _____

Calendar to be followed: _____ District _____School _____ Other
(be specific)

	EI or CPSE/CSE School Year (Sept-June)				SUMMER (CSE/CPSE ONLY)			
Discipline	**Freq**	**Duration**	**Location**	**Agency**	**Freq**	**Duration**	**Location**	**Agency**
Sp.Ed./ SEIT								
Speech								
PT								
OT								
Family Training								

Include in <u>Notes</u> concerns that affect treatment options, e.g. behaviors, feeding, autism red flags etc
Notes:

_____

_____

_____

_____ I hereby give consent for all EI/CPSE/CSE providers working with my child to discuss my child's progress with each other.

Parent Signature _____ **CPSE/CSE Chair/ EIOD/OSC Initials:** _____

Js4/12