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Meeting Results

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

Student: _____ D.O.B _____

County: _____ District: _____

Initial EI/OD: _____ OSC: _____
(Suffolk EI Only) (EI Only)

EI/OD _____ 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)

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

Include in **Notes** 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/ EI/OD/OSC Initials: _____