

Barnstable Public Schools

IEP Team Meeting Summary

Student's Name: _____ Date of Meeting: _____

Type of Meeting: Initial Re-evaluation Review # Revision

ELIGIBILITY:

The Team determined that your child is eligible for special education due to the following educational disability: _____

The team further determined that your child's disability is adversely affecting progress in the general curriculum and that he/she requires specialized instruction &/or related services.

Services Recommended:

Goal Focus Area	Type of Service	Frequency of Service	Grid A: Indirect Services	Grid B: In Gen Ed Setting	Grid C: In Other Setting

GOAL AREAS:

___ The Team discussed child's vulnerability to teasing, harassment, and/or bullying because of his/her educational disability. Action needed? Y or N _____

ADDITIONAL COMMENTS: _____

Form Completed By: _____

Signature Role

*I have received a copy of the IEP Team Meeting Summary:

Parent/Guardian Signature Date