

DISABILITIES - SUMMARY OF SERVICES

CHILD'S NAME _____

DATE	PROGRESS NOTE #	SERVICE
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D1. POTENTIAL DEVELOPMENTAL CONCERN

_____ Concern identified (source of concern)

_____ Concern Discussed with Parent

_____ Internal Referral

_____ Internal Observation (by Head Start)

_____ Release of Information from Parent obtained

D2. PARENT/PROGRAM REFERRAL TO ESD

_____ Referral Date (by Education/Disabilities Director or parent directly to the ESD)

_____ Observations/Evaluations by ESD

_____ Qualified for services Not Qualified for services

D3. DISABILITY DOCUMENTATION

_____ Referral/Summary Form or Letter from ESD

_____ IFSP Eligibility Meeting (MDT DATE)

_____ Disability

_____ Primary _____ Secondary _____ (Only If Documented)

D4. IFSP DATES

Initial IFSP _____

Updated IFSPs _____

Kindergarten Transition mtg _____

D5. SERVICES PROVIDED BY ESD CONSULTANTS/SPECIALISTS

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July
Monthly Observation/feedback												