

# EAST CENTRAL INDIANA SPECIAL SERVICES DATA ENTRY SHEET

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ TOR \_\_\_\_\_

## **ELIGIBILITY**

- ☐ Student qualifies for initial placement in special education. Complete Initial Evaluation Data Sheet.
- ☐ Student continues to qualify for special education services under the same eligibility category.
- ☐ Student's area of eligibility has changed due to a recent reevaluation.
- ☐ Student's special education services have been terminated. Complete Special Education Termination section below.

## **EXCEPTIONALITY AREA** (1=Primary Disability, 2=Secondary Disability)

- |                                                              |                                                           |                                                           |
|--------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> 01-Multiple Disabilities            | <input type="checkbox"/> 06-Emotional Disability (other)  | <input type="checkbox"/> 11-Moderate Cognitive Disability |
| <input type="checkbox"/> 02-Orthopedic Impairment            | <input type="checkbox"/> 07-Specific Learning Disability  | <input type="checkbox"/> 12-Severe Cognitive Disability   |
| <input type="checkbox"/> 03-Blind or Low Vision              | <input type="checkbox"/> 08-Developmental Delay           | <input type="checkbox"/> 14-Deaf-Blind                    |
| <input type="checkbox"/> 04-Deaf or Hard of Hearing          | <input type="checkbox"/> 09-Language or Speech Impairment | <input type="checkbox"/> 15-Autism Spectrum Disorder      |
| <input type="checkbox"/> 05-Emotional Disability (Full Time) | <input type="checkbox"/> 10-Mild Cognitive Disability     | <input type="checkbox"/> 16-Traumatic Brain Injury        |
|                                                              |                                                           | <input type="checkbox"/> 17-Other Health Impairment       |

## **LEAST RESTRICTIVE ENVIRONMENT (LRE)**

### **Preschool**

- ☐ 26-In Reg EC Program 10+, SE in Reg EC Program
- ☐ 27-In Reg EC Program 10+hrs/wk, SE in other service provider location
- ☐ 28-In Reg EC Program less than 10 hr/wk, SE in regular EC program
- ☐ 29-In Reg EC Program less than 10 hr/wk, SE in Other service provider location
- ☐ 33-Separate special education classroom
- ☐ 34-Separate School
- ☐ 35-Residential facility
- ☐ 36-Service provider location
- ☐ 37-Home
- ☐ 38-Child is parentally placed in a private preschool

### **K-12**

- ☐ 50-Regular class 80% or more (in a regular classroom 80% or more/day)
- ☐ 51-Resource room (in a regular classroom for 40%-89% of day)
- ☐ 52-Separate class (in a regular classroom for less than 40% of the day)
- ☐ 53-Separate day school facility
- ☐ 54-Residential facility
- ☐ 55-Correctional facility
- ☐ 56-Parentally placed in private school
- ☐ 57-Homebound/hospital

## **RELATED SERVICES**

- |                                                       |                                                             |                                                            |
|-------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> 20-Audiology                 | <input type="checkbox"/> 28-Counseling Services-SP.Ed.      | <input type="checkbox"/> 36-Parent Counseling and training |
| <input type="checkbox"/> 21-Occupational Therapy      | <input type="checkbox"/> 29-Rehabilitation Counseling       | <input type="checkbox"/> 37-Other Supportive Services      |
| <input type="checkbox"/> 22-Physical Therapy          | <input type="checkbox"/> 30-Special School Health Services  | <input type="checkbox"/> 40-Behavioral Consultant          |
| <input type="checkbox"/> 23-Psychological Services    | <input type="checkbox"/> 32-Orientation and Mobility        | <input type="checkbox"/> Other _____                       |
| <input type="checkbox"/> 24-Recreation Services       | <input type="checkbox"/> 34-Medical Services for Evaluation |                                                            |
| <input type="checkbox"/> 25-School Social Work-Sp.Ed. | <input type="checkbox"/> 35-Transportation                  |                                                            |

## **ACCOMMODATIONS (Circle)**

- |                   |     |    |
|-------------------|-----|----|
| (A) Read Aloud    | Yes | No |
| (B) Braille       | Yes | No |
| (C) Calculator    | Yes | No |
| (E) Extended Time | Yes | No |
| (F) Large Font    | Yes | No |
| (P) Large Print   | Yes | No |

## **ISTEP/ISTAR FIELDS**

- |             |     |    |
|-------------|-----|----|
| ISTAR Taker | Yes | No |
| ISTEP Taker | Yes | No |