

**Radford City Public Schools**

1612 Wadsworth Street

Radford, VA 24141

540-731-3647

Student ID:

FTE Number:

Student Testing ID:

Date of Birth:

**Meeting Notice**

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To: \_\_\_\_\_ Letter Dates: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Date Sent To Participants: \_\_\_\_\_

This is to notify you that an IEP team meeting has been scheduled for the above student. Your participation and attendance at this meeting are very important. This IEP meeting must be scheduled at a mutually agreed upon time and place. The purpose of this meeting is to (check all that apply):

Discuss Reevaluation

Add/Delete Related Services

Component Update

Discuss transition/post-secondary goals

Review of Existing Data

Other

This meeting has been scheduled for: Date \_\_\_\_\_ Time \_\_\_\_\_

Location \_\_\_\_\_

The following are invited to attend and participate in the IEP meeting:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\* If the purpose of the meeting includes the development of transition services needs (beginning at age 14 or younger) the student will be invited. If the purpose of the meeting is the consideration of needed transition services (beginning at age 16 or younger) the student and representatives of the following agencies will be invited:

\_\_\_\_\_

The parent/adult student or school division may invite individuals who have knowledge or special expertise regarding the student, including related services personnel, to participate. The determination of the knowledge or special expertise shall be made by the person/party extending the invitation. If you, the parent or adult student, are bringing other individuals to the meeting, please let us know. This will ensure that the meeting space will accommodate all team members.

If you have any questions or would like additional information or assistance to help you prepare for this IEP meeting, please contact \_\_\_\_\_ at \_\_\_\_\_, e-mail \_\_\_\_\_.

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Date of IEP meetings: \_\_\_\_\_

Student: \_\_\_\_\_

To the Parent/Student

Please check your choice. Detach and return this section to \_\_\_\_\_ Fax \_\_\_\_\_

WILL ATTEND the IEP meeting as scheduled.

CANNOT ATTEND the IEP meeting as scheduled.

I understand the importance of attending. You may hold this meeting in my absence.

Please consider rescheduling this meeting.

(month/day/year)\_\_\_\_\_ at (time/place)\_\_\_\_\_.

Please contact me at \_\_\_\_\_ to determine a mutually agreeable date, time, and place for this IEP meeting.

I can participate by an alternate method (Select an option below).

Other: \_\_\_\_\_

I give permission to proceed without a meeting.

No response - Will proceed with meeting.

Would like my preferences, interests, concerns shared with the IEP team.

I will provide my input to you by: \_\_\_ Mail, \_\_\_ Telephone, \_\_\_ other means \_\_\_\_\_ prior to the meeting.

I will need the following accommodations for this IEP meeting:

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Date received by the school \_\_\_\_\_

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**Excused Team Members**

Student's Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Attending School: \_\_\_\_\_ Grade: \_\_\_\_\_

Home School: \_\_\_\_\_

Parent/Guardian/Surrogate Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_

There is a meeting in reference to your child to be held on (date) \_\_\_\_\_ at (time) \_\_\_\_\_  
at (place) \_\_\_\_\_

The following team members have requested excusal from the meeting:

Name	Title	Reason

If the member's area of the curriculum or related service will not be discussed, the member may be excused without submitting comments in writing. If the member's area of curriculum or related service will be discussed, they may be excused but must provide comments in writing and submit this to the team in lieu of their appearance.

We agree to excuse the above team members from the meeting.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of District Representative

\_\_\_\_\_  
Date

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**Assessment Review**

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Student: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Meeting: \_\_\_\_\_

Student ID: \_\_\_\_\_ Disability: \_\_\_\_\_

Initial Eligibility: \_\_\_\_\_ Most Recent Re-evaluation: \_\_\_\_\_ Next Re-evaluation: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

Component Update

Add/ Delete Related Service

Re-evaluation Review

**Assessment Summaries**

Educational Results: Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

Developmental Results: Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

Audiological Results: Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

Medical Results: Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

Speech and Language Results: Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

Vision Results: Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

Sociocultural Results: Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

Hearing Screening Results: Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

Occupational Therapy Results: Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

Psychological Results: Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

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Results:

Observation Results:      Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

Physical Therapy Results:      Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

Physical Examination Results:      Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

Assistive Technology Results:      Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

Other Results:      Date: \_\_\_\_\_ Evaluator: \_\_\_\_\_

**Reevaluation Review Only:**

Summary of Deliberations      Refer to Eligibility            Yes            No

**Participants**

_____	_____	_____	_____
	Date		Date
_____	_____	_____	_____
	Date		Date
_____	_____	_____	_____
	Date		Date
_____	_____	_____	_____
	Date		Date

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**Reevaluation Notification/Consent**

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Student's Name: \_\_\_\_\_

Student's Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Dear Parent(s),

We are notifying you that your child, \_\_\_\_\_ requires a re-evaluation. The parent/adult student or school division may invite individuals who have knowledge or special expertise regarding the student, including related services personnel, to participate as a member of the eligibility or IEP team. The determination of the knowledge or special expertise shall be made by the person/party extending the invitation. If you, the parent or adult student, are bringing other individuals to the meeting, please let us know. This will ensure that the meeting space will accommodate all team members.

Enclosed with this letter is a copy of your rights as a parent of a child who requires special education or Section 504 services. To obtain assistance in understanding the provisions of this part of your rights, you may contact either \_\_\_\_\_ at \_\_\_\_\_ or \_\_\_\_\_ at \_\_\_\_\_.

The re-evaluation will include the following assessments:

The decision to an evaluation of your child was based on the following:

Before we decided to an evaluation, the school division considered and/or attempted the following options:

These options or strategies were rejected because:

When the assessments are completed, an eligibility/IEP meeting will be held. You will be notified of this meeting in a timely manner so that you may attend.

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**Reevaluation Notification/Consent**

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**Parental Response**

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I understand that I have the opportunity to participate in the consideration of the areas to be assessed. I would suggest the following areas of need be considered in assessing my child:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

I also have been given the statements prepared by the \_\_\_\_\_ that summarize protections for students who may require special education.

These evaluations have been explained and I have been informed of my due process rights in language understandable to me. I give my consent for my child to be re-evaluated.

\_\_\_\_\_  
Parent/Guardian/Surrogate

\_\_\_\_\_  
Date

Please return this form to \_\_\_\_\_ at \_\_\_\_\_.

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I refuse consent for my child to be evaluated.

\_\_\_\_\_  
Parent/Guardian/Surrogate

\_\_\_\_\_  
Date

**Comments:**

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**Consent**

Student's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Student ID Number: \_\_\_\_\_

**Placement Decision**

The school division proposes to implement this IEP. This proposed IEP will allow the student to receive a free appropriate public education in the least restrictive environment. This decision is based upon a review of current records, current assessments and the student's performance as documented in the Present Level of Academic Achievement and Functional Performance. Parent and adult student rights are explained in Your Family's Special Education Rights--Virginia Procedural Safeguards Notice (revised August 2009). If you, the parent(s) and adult student, need another copy of Your Family's Special Education Rights--Virginia Procedural Safeguards Notice (revised August 2009) or need assistance in understanding this information please contact

\_\_\_\_\_ at \_\_\_\_\_  
e-mail \_\_\_\_\_ or

\_\_\_\_\_ at \_\_\_\_\_  
e-mail \_\_\_\_\_.

\_\_\_\_\_ Parent(s) initials here indicate that the parent(s) has read the above prior notice and attachments, if any, before giving permission to implement this IEP and the placement decision.

**Parent/Adult Student Consent:** Indicate your response by checking the appropriate space and sign below.

**I give** permission to implement this IEP and the placement decision.

**I do not give** permission to implement this IEP and the placement decision.

I understand that my child's IEP committee met on \_\_\_\_\_ and determined, based on a review of data obtained, that my child is no longer eligible for the related service of \_\_\_\_\_

**I give** consent for the termination of this related service, \_\_\_\_\_, for my child.

**I do not** consent for the termination of this related service, \_\_\_\_\_, for my child.

I have received a copy of my rights as a parent of a child eligible for special education services.

I have been given information on assessment participation for students with disabilities.

\_\_\_\_\_  
Parent Signature or Adult Student Signature (if appropriate)

\_\_\_\_\_  
Date

**Transfer of Rights at the Age of Majority (Age 18):**

Indicate the date that the student and parent were informed of the transfer of parental rights under IDEA to the adult student at the age of 18. This must occur at least one year prior to the age of 18.

\_\_\_\_\_  
Date School Official Signature

I was informed of the parental rights under IDEA and that these rights transfer to me at age 18.

\_\_\_\_\_  
Date Student Signature

I was informed of the parental rights under IDEA that transfer to my child at age 18.

\_\_\_\_\_  
Date Parent Signature



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**Prior Notice**

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Actions proposed or refused by Radford City Public Schools:

Rationale for why actions were proposed or refused:

Other options considered:

Reasons why options were rejected:

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Description of any assessment data or reports used to make the decision:

Other factors relevant to proposal or refusal:

Follow-up meeting date, if appropriate: \_\_\_\_\_

**Note:**

The parents of a child with a disability have protection under Your Family's Special Education Rights--Virginia Procedural Safeguards Notice (revised August 2009) of the Individuals with Disabilities Education Act. A copy of Your Family's Special Education Rights--Virginia Procedural Safeguards Notice (revised August 2009) has already been given to you OR is enclosed with this document. Should you need an additional copy of Your Family's Special Education Rights--Virginia Procedural Safeguards Notice (revised August 2009), please contact the Special Education Office. To obtain assistance in understanding the provisions of this notice, contact the Office of Special Education at:

\_\_\_\_\_ at \_\_\_\_\_  
e-mail \_\_\_\_\_ or

\_\_\_\_\_ at \_\_\_\_\_  
e-mail \_\_\_\_\_