Educational Service Center of Central Ohio

Meeting Minutes

Student: _____ Date of Birth: _____

Program: _____ Meeting Type: ☐Initial ☐Annual Review

Committee Members Present: ☐ Other ☐Periodic Review ☐MFE

Coordinator_____ SLP_____

IS _____ OT_____

Teacher_____ APE_____

Transition_____ PT_____

Other_____ MH_____

Other_____ Behavior_____

Agency:_____

Home District Representative(s):_____

Parent/ Guardian(s):_____

COMMENTS:

Materials Submitted: ☐Current IEP ☐Medical Eval. ☐Multifactored Evaluation ☐Immunization (Health Folder)

☐Cumulative Folder ☐Birth Certificate ☐Audiological ☐SS# or Student ID#_____

Recommendation:

_____ _____

Recorder Date of Meeting

Copies of IEP given to: ☐Parent ☐District ☐Agency EMIS given to: ☐District