

INDIVIDUAL EDUCATIONAL PLANNING
IEP Planning Sheet for Parents

Student's Name: _____ **Date:** _____

Parent's Name: _____

To develop the best possible program, we need your assistance and knowledge of your child. Below are some questions for you to answer in preparation for the IEP meeting. Please write down your thoughts and send this form back to _____. The information that you share will be used to prepare a draft profile or word picture about your child.

❖ What do you feel are the strengths of your child? _____

❖ What do you feel are your child's weaknesses (e.g., areas that may be frustrating or that you feel your child has a particular need to improve)? _____

❖ How do you think your child learns best? (What kind of situation makes learning easiest?)

❖ Please describe educational skills that your child practices at home regularly (e.g., reading, making crafts, taking things apart, putting things together, using the computer, coloring).

❖ Does your child have any behaviors that are of concern to you or other family members? (If so, please describe the behavior(s). _____

❖ What are your child's favorite activities? _____

❖ What are your child's special talents or hobbies? _____

- ❖ Does your child have a history of ear infections or frequent upper respiratory infection?

- ❖ When was the last eye examination completed with your child? _____
- ❖ Is there a history of speech delay/language delay in your family (grandparent, parent, sibling)?

- ❖ How does your child usually react when upset and how do you deal with the behavior?

- ❖ If you have particular concerns about your child's school program this year, please describe them. _____

- ❖ What are your main hopes for your child this year? _____

- ❖ Please list any other information that would help us gain a better understanding of your child.

- ❖ Are there any concerns that you would like to discuss at the next IEP meeting? _____

Thank you for contributing valuable parental insights.

INDIVIDUAL EDUCATIONAL PLANNING

IEP Planning Sheet for Parents

Student's Name: _____ Date: _____

Parent's Name: _____

To develop the best possible program, we need your assistance and knowledge of your child. Below are some questions for you to think about in preparation for the IEP meeting. Please write any additional thoughts and/or information that you wish to include for future reference by the IEP Team.

- What do you feel are the strengths of your child?

- | | | |
|---|---|---|
| <input type="checkbox"/> Tries new things | <input type="checkbox"/> Has a sense of humor | <input type="checkbox"/> Does well in home activities |
| <input type="checkbox"/> Makes new friends easily | <input type="checkbox"/> Has neat ideas | <input type="checkbox"/> Says, "please" and "thank you" |
| <input type="checkbox"/> Encourages others | <input type="checkbox"/> Talks clearly | <input type="checkbox"/> Is happy |
| <input type="checkbox"/> Offers help to others | <input type="checkbox"/> Good feelings about self | <input type="checkbox"/> Plays well with other children |
| <input type="checkbox"/> Likes books | <input type="checkbox"/> Understands what is said | <input type="checkbox"/> Is a good sport |
| <input type="checkbox"/> Admits mistakes | <input type="checkbox"/> Listens attentively | <input type="checkbox"/> Has good eye contact |
| <input type="checkbox"/> Does chores when asked | <input type="checkbox"/> Follows instructions | <input type="checkbox"/> Has good appetite |
| <input type="checkbox"/> Does homework | <input type="checkbox"/> Asks for help | <input type="checkbox"/> Has limited fears |
| <input type="checkbox"/> Does not give up easily | <input type="checkbox"/> Keeps trying | <input type="checkbox"/> Makes self understood |
| <input type="checkbox"/> Adjusts well to changes in routine | <input type="checkbox"/> Adjusts well to different people | <input type="checkbox"/> Proud of self |
| <input type="checkbox"/> Likes music | <input type="checkbox"/> Likes to be read to | <input type="checkbox"/> Smiles at people |
- _____
- _____
- _____

- What do you feel are your child's weaknesses (e.g., areas that may be frustrating or that you feel your child has a particular need to improve)?

- | | | |
|--|--|---|
| <input type="checkbox"/> Argues with you | <input type="checkbox"/> Is too serious | <input type="checkbox"/> Is easily distracted |
| <input type="checkbox"/> Eats things that are not food | <input type="checkbox"/> Acts without thinking | <input type="checkbox"/> Trouble making friends |
| <input type="checkbox"/> Trouble with going from one task to another | <input type="checkbox"/> Won't do work | <input type="checkbox"/> Worries about others |
| <input type="checkbox"/> Worries about what parents think | <input type="checkbox"/> Breaks things | <input type="checkbox"/> Does not speak clearly |
| <input type="checkbox"/> Stays mad a long time | <input type="checkbox"/> Does not listen well | <input type="checkbox"/> Does not ask for help |
| <input type="checkbox"/> Refuses help | <input type="checkbox"/> Has eye problems | <input type="checkbox"/> Is critical of self |
| <input type="checkbox"/> Complains about work | <input type="checkbox"/> Has fears | <input type="checkbox"/> Does not smile |
| <input type="checkbox"/> Does not seem happy | <input type="checkbox"/> Forgets things | <input type="checkbox"/> Has ear problems |
| <input type="checkbox"/> Does not adjust well to change | <input type="checkbox"/> Tries to hurt self | <input type="checkbox"/> Has a short attention span |
| <input type="checkbox"/> Is nervous | <input type="checkbox"/> Has fevers | <input type="checkbox"/> Whines |
| <input type="checkbox"/> Screams | <input type="checkbox"/> Needs to be shown how to do something | <input type="checkbox"/> Needs a lot of supervision |
| <input type="checkbox"/> Is overly active | <input type="checkbox"/> Always wants to be right | <input type="checkbox"/> Is sick a lot |
| | <input type="checkbox"/> Daydreams | <input type="checkbox"/> Is easily upset |
| | | <input type="checkbox"/> Has toileting accidents |

- | | | |
|--|---|---|
| <input type="checkbox"/> Does not understand the first time he/she hears something | <input type="checkbox"/> Gets upset when things are lost | <input type="checkbox"/> Bullies brothers/sisters |
| <input type="checkbox"/> Needs very simple directions | <input type="checkbox"/> Has bad allergies | <input type="checkbox"/> Has frequent colds |
| <input type="checkbox"/> Is nervous about answering | <input type="checkbox"/> Has a short attention span | <input type="checkbox"/> Climbs on things |
| <input type="checkbox"/> Stares blankly | <input type="checkbox"/> Repeats one thought over and over | <input type="checkbox"/> Cries easily |
| <input type="checkbox"/> Won't mind | <input type="checkbox"/> Gets mad if he/she doesn't get own way | <input type="checkbox"/> Has seizures |
| <input type="checkbox"/> Can't understand math | <input type="checkbox"/> Can't read | <input type="checkbox"/> Won't read |
| <input type="checkbox"/> Does not play well with others | <input type="checkbox"/> Won't do math homework | <input type="checkbox"/> Throws temper tantrums |
| <input type="checkbox"/> Does not talk very well | <input type="checkbox"/> Hits others | <input type="checkbox"/> Is shy with others |
| <input type="checkbox"/> Does not make all the sounds right when he/she talks | <input type="checkbox"/> Cannot say what he/she is thinking about without a long wait | <input type="checkbox"/> Stays sick a lot |
| <input type="checkbox"/> Gets mad/angry when he/she can't do something fast | | <input type="checkbox"/> Has ear infections |
| | | <input type="checkbox"/> Does not laugh much |
| | | <input type="checkbox"/> Is afraid of dying |
| | | <input type="checkbox"/> Breaks things |

• How do you think your child learns best? (What kind of situation makes learning easiest)?

- | | |
|--|---|
| <input type="checkbox"/> One on one with a teacher | <input type="checkbox"/> One on one with a friend |
| <input type="checkbox"/> One on one with parent | <input type="checkbox"/> One on one with sister/brother |
| <input type="checkbox"/> Working with picture books | <input type="checkbox"/> With work sheets |
| <input type="checkbox"/> With objects (like for counting) | <input type="checkbox"/> Working in a classroom |
| <input type="checkbox"/> Watching someone else do the activity first | <input type="checkbox"/> With lots of rewording of the directions |
| <input type="checkbox"/> When my child is close to the one teaching | <input type="checkbox"/> With no noise in the room |
| <input type="checkbox"/> With music | <input type="checkbox"/> With the computer as a tool |
| <input type="checkbox"/> With my child in my lap | <input type="checkbox"/> With my child sitting next to me in a soft chair |
| <input type="checkbox"/> With my child seated at a table | <input type="checkbox"/> With my child seated at a desk |
| <input type="checkbox"/> With the lights turned on low | <input type="checkbox"/> With bright light in the room |
| <input type="checkbox"/> With a snack | <input type="checkbox"/> Without food around |
| <input type="checkbox"/> With the TV/radio on | <input type="checkbox"/> With no TV/radio on |

• Please describe educational skills that your child practices at home regularly (e.g., reading, crafts, using the computer).

- | | |
|--|--|
| <input type="checkbox"/> Reads to parent every day | <input type="checkbox"/> Reads to brother/sister every day |
| <input type="checkbox"/> Works on math every day | <input type="checkbox"/> Draws pictures with pencil, crayons, markers |
| <input type="checkbox"/> Likes to make cookies | <input type="checkbox"/> Uses the computer every day to do math, reading |
| <input type="checkbox"/> Likes to make crafts | |

Does your child have any behaviors that are of concern to you or other family members? If so, please describe the behavior(s).

- | | | |
|--|---|--|
| <input type="checkbox"/> Wets bed at night | <input type="checkbox"/> Says, "I wish I were dead" | <input type="checkbox"/> Argues about everything |
| <input type="checkbox"/> Breaks things | <input type="checkbox"/> Does not sleep well | <input type="checkbox"/> Refuses to go to bed |

- | | | |
|---|---|---|
| <input type="checkbox"/> Refuses to do homework | <input type="checkbox"/> Tantrums | <input type="checkbox"/> Argues a lot |
| <input type="checkbox"/> Is sad | <input type="checkbox"/> Has stomach problems | <input type="checkbox"/> Has allergies |
| <input type="checkbox"/> Makes noises when playing | <input type="checkbox"/> Refuses to play with others | <input type="checkbox"/> Babbles to self |
| <input type="checkbox"/> Acts without thinking | <input type="checkbox"/> Complains about health | <input type="checkbox"/> Has headaches |
| <input type="checkbox"/> Stays alone all the time | <input type="checkbox"/> Is easily distracted | <input type="checkbox"/> Is too serious |
| <input type="checkbox"/> Voice is scratchy sounding | <input type="checkbox"/> Does not laugh/smile | <input type="checkbox"/> Stutters |
| <input type="checkbox"/> Screams | <input type="checkbox"/> Talks about dying | <input type="checkbox"/> Plays with own sex parts |
| <input type="checkbox"/> Does not seem able to finish something | <input type="checkbox"/> Says, "Nobody likes me" | <input type="checkbox"/> Bites nails |
| <input type="checkbox"/> Threatens to hurt others | <input type="checkbox"/> Has trouble making decisions | <input type="checkbox"/> Is easily frustrated |
| | <input type="checkbox"/> Uses foul language | <input type="checkbox"/> Does not talk plain |

- What are your child's special talents or hobbies?

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Music | <input type="checkbox"/> Coloring | <input type="checkbox"/> Riding horses |
| <input type="checkbox"/> Telling stories | <input type="checkbox"/> Reading | <input type="checkbox"/> Memorizing |
| <input type="checkbox"/> Saying poetry | <input type="checkbox"/> Dressing up | <input type="checkbox"/> Bicycling |
| <input type="checkbox"/> Remembering information | <input type="checkbox"/> Cooking | <input type="checkbox"/> Gardening |
| <input type="checkbox"/> Art | <input type="checkbox"/> Photography | <input type="checkbox"/> Working puzzles |
| <input type="checkbox"/> Writing stories | | |

- What are your child's favorite activities?

- Does your child have any particular fears? If so, please describe.

- How does your child usually react when upset and how do you deal with the behavior?

- Do you have any particular concerns about your child's school program this year? If so, please describe.

- What are your main hopes for your child this year?

- Is there other information that would help us gain a better understanding of your child?

- Are there any concerns that you would like to discuss at the next IEP meeting?

Thank you for contributing valuable parental insights.

Sincerely,

(IEP Team Coordinator)

STUDENT PROFILE INFORMATION
(HAVE STUDENT COMPLETE THIS FORM EACH YEAR)

FULL NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

NAMES OF PARENT(S): _____

YOU LIVE WITH BOTH PARENTS: _____, ONE PARENT: _____

OTHER THAN PARENT: _____ WHO? _____

NUMBER OF SISTER(S): _____ NUMBER OF BROTHER(S): _____

FAVORITE SPORT(S): _____

FAVORITE SCHOOL SUBJECT(S): _____

HOBBIES: _____

CHURCH: _____

CLUBS OR ORGANIZATIONS YOU ARE A MEMBER: _____

SPORTS YOU PLAY: _____

MEDICAL PROBLEM(S): _____

DO YOU TAKE MEDICINE? _____ FOR WHAT? _____

FUTURE JOB OR PLANS: _____

CLASSES YOU WANT TO TAKE NEXT YEAR: 1. _____ 2. _____

3. _____ 4. _____ 5. _____ 6. _____

7. _____ 8. _____

TEACHER'S IEP INPUT SURVEY

Teacher's Name: _____ Date: _____

Student's Name: _____

Subject: _____ Case Manager: _____

Please give responses to the following items:

1. How does the child participate in class instructions (stays on task, answers or responses in class, etc.)?

2. How does he/she interact or get along with peers/teachers?

3. What are some areas or activities that he/she needs to improve on in your class or did not successfully complete?

4. What were some activities that he/she completed successfully in your class or at school?

5. Did you provide any modifications or accommodations, if so, what?

6. Do you think he/she can progress in general education classes without special education services? If so, explain.

PARENT'S IEP INPUT SURVEY

Parent's Name: _____ **Date:** _____

Student's Name: _____

Teacher's Name: _____

Please complete the following items and return this form to the above teacher at the school:

1. How does the child participate in home jobs/tasks (stays on task, etc.)?

2. How does he/she interact or get along with family members/classmates/teachers?

3. What are some areas or activities that your child needs to improve or did not complete successfully at home or school that you would like to get some support for him/her?

4. What were some activities that your child did complete successfully or did well at home or at school?

5. Other comments, questions, suggestions.
