|  |  |  |  |
| --- | --- | --- | --- |
| **SEIT Quarterly Progress Report**  **Please check one: \_\_\_\_\_\_\_\_November \_\_\_\_\_\_\_\_February \_\_\_\_\_\_\_\_\_\_May \_\_\_\_\_\_\_\_\_August 20\_\_\_** | | | |
| **Student’s Name:** |  | **DOB:** | **NYC ID:** |
| **Latest IEP date:** |  | **SEIT Mandate:** | |
| **Teacher, title:** |  | | |

**INTRODUCTION/PRESENT LEVEL OF FUNCTIONING:**

**CONCLUSION/RECOMMENDATIONS TOWARDS PROGRESS:**

* The extent to which progress is sufficient to enable the child of achieving the IEP and annual goals by the end of the IEP period:
* Suggested modifications to the duration and frequency of educational/related service(s), if any, and recommended changes to goals and objectives, if any:

**Services Currently Being Provided (as per the IEP):**

|  |  |  |
| --- | --- | --- |
| **Discipline** | **Provider’s Name** | **Mandate** |
| SEIT |  |  |
| SLP |  |  |
| OT |  |  |
| PT |  |  |
| Other |  |  |

**\***If any related services are still to be established, please remind the parent(s) to contact the CPSE administrator.

**Related Services Quarterly Collaboration Log:**

|  |  |  |
| --- | --- | --- |
| **Collaboration with RS Provider(s)**  ***Perform and document outcomes of collaboration with assigned related services provider(s), in regard to IEP goals, current functioning level, progress, and recommendations from team member(s).*** | **Way of Communication** | **Date** |
|  |  |  |

**PARENT/TEACHER CONFERENCE Comments/Notes (Discuss the quarterly progress with the parents and list and comments/concerns parents reported):**

**Parent Quarterly Collaboration Log:**

|  |  |  |
| --- | --- | --- |
| **Collaboration with Parents**  ***Perform and document outcomes of collaboration with parents, in regard to IEP goals, current functioning level, progress, and recommendations from team member(s).*** | **Parent's Name(s)** | **Date(s)** |
|  |  |  |

Parent’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_