

INTERIM PLACEMENT

Student Name	First	Middle	Last	D.O.B.	Age	Sex
Social Security #			SELPA ID		Grade	
Name of Parent/Guardian				Phone: Home	Work	
Address			Apt. #	City	Zip	
District of Residence						
Home Language			Student's Language			
Migrant Ed: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Limited English Proficient <input type="checkbox"/> Yes <input type="checkbox"/> No						
ETHNICITY						
<input type="checkbox"/> Native American <input type="checkbox"/> Hispanic						
<input type="checkbox"/> African American <input type="checkbox"/> White						
<input type="checkbox"/> Other _____						

DATES

Today's Date ____/____/____
 30 Day Review ____/____/____
 Last Triennial ____/____/____
 Last IEP ____/____/____
 Next IEP ____/____/____

AGENCY INVOLVEMENT

CA Child. Services (CCS) Dept. of Rehabilitation
 Dept. of Mental Health Kern Regional Center
 Dept. of Human Services
 Other _____

RESIDENCY

Parent/Guardian FFH/LCI _____
 Name _____
 Surrogate needed Yes No

PRIMARY DISABILITY CATEGORY

Specific Learning Disability Speech/Lang. Impaired
 Hard of Hearing Other Health Impaired
 Deaf Mental Retardation
 Deaf-Blind Multiple Disabilities
 Visually Impaired Autistic
 Orthopedically Impaired Traumatic Brain Injury
 Emotionally Disturbed Estab. Med. Disability (0-5 yrs.)

PRIMARY PLACEMENT

General Education
 Designated Instruction
 Resource Specialist
 Special Day Class
 Non Public School
 Other _____

AGENCY SERVICES

KRC DMH CCS other _____
(attach treatment plan)

PRIMARY SERVICE LOCATION

SPECIAL EDUCATION TRANSPORTATION

Yes No By: _____

PARENTAL CONSENT (Please initial areas that are acceptable)

____ I received a notice of my Parental Rights and Procedural Safeguards for Special Education and have had them explained.
 ____ I agree with the interim placement.
 ____ I agree with the interim service recommendations.

 Signature of Parent/Surrogate/Guardian Date

In addition to the parents, the following were participants in the Interim Placement decision.

 School District Representative Date

 Additional Participant/Title Date

 Additional Participant/Title Date

 Additional Participant/Title Date

PRIMARY PLACEMENT/DESIGNATED INSTRUCTION AND SERVICES

Service	Start/End Date	Frequency/Time* (circle one)	Location
_____	_____	____/____ per wk / mo / yr	_____
_____	_____	____/____ per wk / mo / yr	_____
_____	_____	____/____ per wk / mo / yr	_____
_____	_____	____/____ per wk / mo / yr	_____

*Excluding non-student days per school calendar.
 Time in Regular Ed _____ Time in Special Ed _____

HEALTH
 Significant health/medical problems (including medication if any): _____

VERIFICATION OF PREVIOUS PLACEMENT
 Made with: _____
 School District/Site

Address _____ Phone _____

Date of verification: ____/____/____ A current IEP is attached: Yes No
 (If No, complete "Goals and Objectives" IEP page and obtain copy of last IEP from prior district.)

Additional Information: _____

