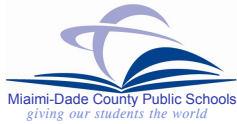


Print Student's Name:	ID#:	Date:
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EXTENDED SCHOOL YEAR (ESY) SERVICES FORM

The following ESY services are deemed appropriate by the IEP team at a meeting held on _____. Parent(s)/guardian(s) will be notified of the location(s) and times for the delivery of school based services. (MM/DD/YY)

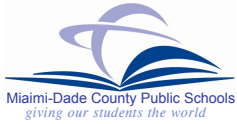
ESY Service Code(s)*	Specialized Instruction, Supplementary, and/or Related Services	Delivery Model Code(s)**	Duration Start - End MM/DD/YY - MM/DD/YY	Frequency ___ day(s)/week for ___ min./session; ___ time(s)/month

Additional Information: _____

The student requires the related service of transportation to access ESY services. Yes No
(If yes, complete the transportation information on page 2 of this form, and fax it to the director for the transportation center who is currently transporting the student.)

Parent Signature: _____	Student Signature: _____	Date: _____
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- * ESY Service Codes:**
ACS=Academic goals; **AT**=Assistive Technology; **ART**=Art Therapy; **BHS**=Behavior/Social Skills goals; **CO**=Counseling; **ITN**=Itinerant Services; **JOB**=Job Coach; **MUS**=Music Therapy; **OM**=Orientation & Mobility; **OT**=Occupational Therapy; **PAR**=Paraprofessional Assistance; **PE**=Specially Designated/Adapted PE; **PT**=Physical Therapy; **RBD**=Recording for the Blind & Dyslexic; **SL**=Speech and/or Language Therapy; **SLI**=Sign Language Interpreter; **OTH**=Other.
- ** Delivery Model Codes:**
HPC=Home packet with consultation; **HP**=Home packet with parent supervision; **H**=home delivery; **S**=School based delivery; **OTH**=Other.



Print Student's Name: _____	ID#: _____	Date: _____
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EXTENDED SCHOOL YEAR (ESY) SERVICES FORM: TRANSPORTATION INFORMATION N/A

Parent(s)/guardian(s) will be notified of transportation pick-up and drop-off times by the transportation office. Notification of the location(s) for delivery of services will also be provided prior to the initiation of services.

Current Assigned School Name: _____ WL#: _____

Home Address: _____

If other than home address: Pick-Up: _____ Drop-Off: _____

Emergency Contact Information: _____

Additional transportation related information: _____

PRIMARY TRANSPORTATION MODE (Check one only)			
<input type="checkbox"/> Individualized Stop With Supervision	<input type="checkbox"/> Individualized Stop Without Supervision	<input type="checkbox"/> Lift Bus With Supervision	<input type="checkbox"/> Lift Bus Without Supervision
<input type="checkbox"/> Car Seat (under 40 lbs.)	<input type="checkbox"/> Safety Vest Individualized Stop With Supervision	<input type="checkbox"/> Safety Belt/Unique Seating Device Individualized Stop With Supervision	<input type="checkbox"/> Alternate Mode of Transportation May Be Required*
*Specify: _____			
SECONDARY TRANSPORTATION MODE(S) (Check all that apply)			
<input type="checkbox"/> Medically Fragile Student (Refer to Medical Consultative Review Procedures)	<input type="checkbox"/> Aide Required	<input type="checkbox"/> Medical Equipment**	<input type="checkbox"/> Shortened School Day or Alternate School Day Time(s)
<input type="checkbox"/> Student Transported Out of School District	<input type="checkbox"/> Occupational/Physical Therapy	<input type="checkbox"/> Vocational/Share Time Program	<input type="checkbox"/> Scholarship Program for Students With Disabilities
**Specify: _____			