Step Up Therapy Services

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Phone (718)434-1200 Fax (718)434-1099

Educational Age Out Report

Student's Name: _____ **DOB:** _____ **NYC #** _____

Mandate: _____ **First Attendance Day:** _____ **Location:** _____

Related Services: _____

Teacher's Name: _____

- **Review of the <u>educational service(s)</u> and description of the student's <u>responses</u> to the service**

  1. **Background Information:**

  2. **Clinical Observation:**

- **Review of the <u>IEP goals</u> & objectives and the student's current <u>levels of performance</u> in achieving the goals**

<u>Annual Goal 1:</u>

<u>Annual Goal 2:</u>

<u>Annual Goal 3:</u>

Annual Goal 4:

Annual Goal 5:

Annual Goal 6:

Cognitive Skills:

a) Child's Strengths:

b) Child's weaknesses:

Social-Emotional Skills:

a) Child's Strengths:

b) Child's weaknesses:

Communication Skills:

a) Child's Strengths:

b) Child's weaknesses:

Self Help Skills:

a) Child's Strengths:

b) Child's weaknesses:

Motor Skills:

a) Child's Strengths:

b) Child's weaknesses:

- **Placement recommendations for the next school year.**

Provider Signature _____ Date _____