



## INDIVIDUALIZED EDUCATION PROGRAMME (IEP) FOR MENTALLY CHALLENGED CHILDREN (MCC)

Name of Student: \_\_\_\_\_

Class: \_\_\_\_\_

Disability: \_\_\_\_\_

Time line (Academic Session): \_\_\_\_\_

Date of Initiation: \_\_\_\_\_

Duration (Term/Month): \_\_\_\_\_

### Signature of Committee Members:

Name:

Signature:

Supervised by: (Head of Institution) \_\_\_\_\_

Implemented by Class Teacher: \_\_\_\_\_

Related service provider (Psychologist): \_\_\_\_\_

Related service provider (Speech Therapist): \_\_\_\_\_

Parents / Guardian: \_\_\_\_\_

Any other Member (if required) \_\_\_\_\_

### Parents' Consent:

I agree with the purpose of IEP, I have been informed of my rights in due process. I understand that I have right to review the child's record and request change in placement. I have \_\_\_ / have not \_\_\_ participated in development of my child's IEP.

Parents' Signature \_\_\_\_\_



## Current Level of Functioning\*

Functional Academics:	Adaptive Functioning Domains/Skills:
Reading:	<b><u>Conceptual</u></b> Cognition:  Language:
Writing:	<b><u>Social</u></b> Interpersonal skills: Intrapersonal skills:
Maths:	<b><u>Practical</u></b> Daily living skills: Motor skills: -Fine motor skills -Gross motor skills Use of community resources:

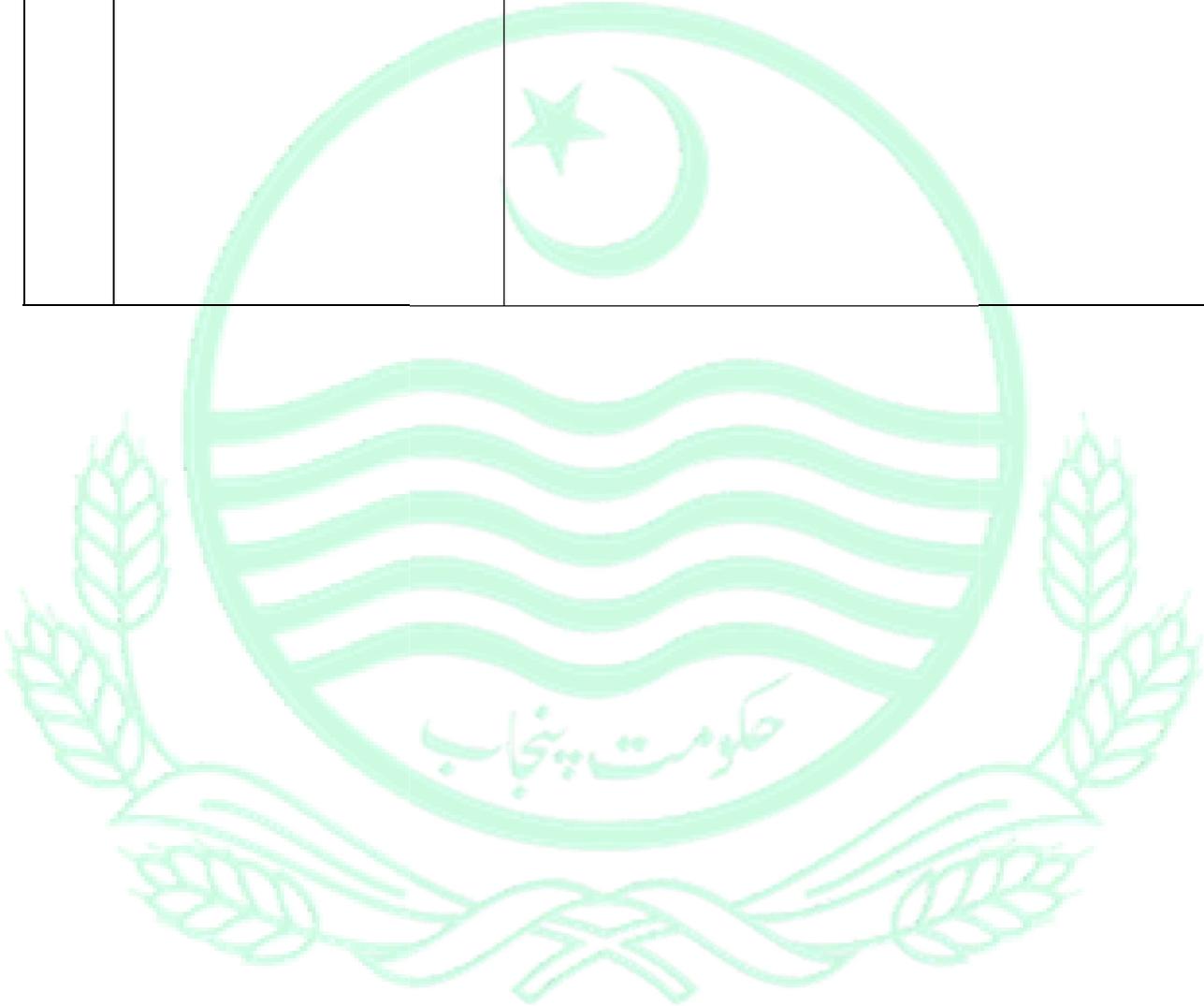
Note: \* please mention the current functioning level of child in functional academics and adaptive functioning domains / skills.

Strengths**	Weaknesses**

Note: \*\* Please mention the skill areas / domains in which child can perform well and those in which child may need support / assistance.



<b>(Name of skill / domain e.g. Fine Motor Skills)</b>		
<b>Sr #</b>	<b>Goals*</b>	<b>Objectives and Criteria Specifications**</b>
	e.g. Color within boundaries	e.g. <b>Objective:</b> (student name) will be able to do coloring within the boundaries <b>Criteria:</b> (student name) will complete the task without assistance with 80% accuracy.



Note: \* please write the goals for each domain /skill area in which child needs support/assistance/training. \*\* write down objectives (at least two) for each domain / skill area with criteria specifications.

**Support Needs/Services: (if required)**

Sr .#	Support Needs:	Support Service Provider(s)	Session / week / month	Duration	Evaluation Criteria
	Occupational needs	Occupational therapist / Special Education Teacher/Vocational Teacher			
	Sensory therapy needs	Sensory therapist/Music Teacher			
	Speech & language needs	Speech therapist			
	Behavior Management needs	Psychologist			
	Physiotherapy needs	Physiotherapist/Instructor physical Education			

**Recommendations:**

He / She will receive \_\_\_\_\_ session(s) in a Week / Month from Special Education Teacher / related service (s) provider. Criteria of achievement will include mastery of skill (s) / item in at least two settings without failure in 3 consecutive trials.

Stamp & Signature Head of Institution