Ionia County Intermediate School District - Script for Personal Care Services

(These services, under which assistance is needed, must be described in the IEP via the PLAAFP; describe both the condition and the need)

Student Name:_____ Resident District: _____ Operating District:_____ IEPC Meeting Date:_____

1) Student's disability:_____

2) The student currently requires assistance in the following areas: (check as applicable) These areas will be documented via the "Health Care Related Needs" form.

A. Personal Health Care Management

- ☐ 1. Assisting/monitoring eating/feeding/meal preparation
- ☐ 2. Assisting/monitory toileting/skin care/bathing/personal hygiene/ maintaining continence
- ☐ 3. Assisting/monitoring grooming
- ☐ 4. Assisting/monitoring dressing
- ☐ 5. Assisting/monitoring transferring/ambulation/mobility/positioning
- ☐ 6. Assisting/monitoring moving around the class, building, grounds
- ☐ 7. Monitoring health conditions, administering medication/procedures
- ☐ 8. Respiratory assistance
- ☐ 9. Assistance with self administered medications
- ☐ 10. Health related functions through hands-on assistance, supervision & cueing
- ☐ 11. Other: _____

B. Behavior Management

- ☐ 1. Prompting appropriate behavior/redirection & intervention for behavior
- ☐ 2. Administering formal behavior management procedures (e.g. token economy, intensive feedback)
- ☐ 3. Crisis intervention
- ☐ 4. Monitoring "time out" procedures
- ☐ 5. Carrying out observation procedures (e.g., time on task, interaction pattern, behavior frequency)
- ☐ 6. Other: _____

Case Manager _____ _____
Signature Date

Program Supervisor _____ _____
Signature Date

Team Members: (Participating in IEP)

Name	**Role**
_____	_____
_____	_____
_____	_____
_____	_____

Physician Authorization OR Authorized Official

I have reviewed the student's record and verified that this service is required.

Physician/
Authorized Official Signature: _____ Date: _____

Revised: Feb 2010/jll