

St. Lucie Public Schools  
 Exceptional Student Education – Audit Checklist

<b>Student:</b>	<b>Number:</b> 56
-----------------	-------------------

Last, First

<b>Program:</b> Dual-Sensory Impaired (DSI)	<b>Program Code:</b> <input type="radio"/>
---	--

<b>Optional Pre-referral</b>	<b>Date Completed:</b>
The student has a medical report from a physician licensed in Florida in accordance with Chapter 458 or Chapter 463, F.S., confirming the existence of such a medical condition having the potential for dual sensory loss to include the diagnosis, its prognosis, and the potential for dual sensory loss	

<b>Date Parent/Guardian gave written consent to conduct an evaluation</b>	
---	--

<b>Evaluations required:</b>	<b>Date Completed:</b>
A medical eye exam by an ophthalmologist or optometrist licensed in Florida in accordance with Chapter 458 or Chapter 463, F.S., describing etiology, diagnosis, treatment regimen, prognosis, near and distance vision, corrected and uncorrected acuity measures for left eye, right eye, and both eyes, measure of field of vision, and recommendations for lighting levels, physical activity, aids, or use of glasses, as appropriate;	
An audiological evaluation	
A functional vision evaluation	
A functional hearing assessment	
An assessment of social development	
An evaluation of receptive and expressive communication by a speech and language pathologist	
A learning media assessment	
If appropriate, an orientation and mobility assessment and sign language assessment	
If available, a medical report from a physician licensed in Florida in accordance with Chapter 458 or Chapter 463, F.S., unless a report of a medical examination from a physician licensed in another state is permitted in accordance with Rule 6A-6.0331(3)(e), F.A.C., describing the etiology or diagnosis of the student's medical condition that does, or has the potential to, result in dual sensory loss.	

Date(s) of parental contact for eligibility meeting (meeting notice)		
Date of eligibility determination		
Date(s) of parental contact for initial IEP (meeting notice)		
Date of initial IEP		
Date parent signed consent for placement		
Evaluation Completion Date		Triennial Reevaluation Date

<b>Evaluation Source:</b>	<input type="checkbox"/> SLC	<input type="checkbox"/> In-State Transfer	<input type="checkbox"/> SLC/Out-of-State Transfer
---------------------------	------------------------------	--	--

(Florida initial eligibility criteria met)

<b>Dismissal Date:</b>	
------------------------	--