NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program

ANNUAL REVIEW PROGRESS REPORT
RELATED SERVICE

Name of Student:	Chronological Age: Student's Date of Birth:
Date of Report:	Related Service Provider:
Related Service:	Provider Agency (if applicable): Little Treasures Associates
School District:	IEP Dates of Service:

Assessments Administered (Formal/Informal): Assessment Scores/Results*:

Date of Testing/Assessment	Type of Testing/Assessment
_____	_____ ____
_____	_____

Current level of functioning: Must include objective data (could be age equivalent score, percentile score or standard deviations)

Summary of Assessment Results and progress toward Goal(s) and Objectives(s):

Date Signature of Related Service Provider Title

CC: Student's CPSE Chairperson
Parents/Guardians