

GIFTED INDIVIDUALIZED EDUCATION PROGRAM (GIEP)

***** Gifted Student

School Year: _____ GIEP Team Meeting Date _____

Student ID #: _____

Student Name: _____ DOB: _____ Age: _____

Student E-mail: _____

Parent Name: _____ Grade: _____

Address: _____ Phone: (H) _____

_____ (W) _____

_____ E-mail: (H) _____

_____ (W) _____

School District: _____

County of Residence: _____ Other Information: _____

GIEP TEAM PARTICIPANTS

The Gifted Individualized Education Program (GIEP) Team makes the decisions about the student's program and placement. Required members of the GIEP team are: the student's parent(s), the student (if appropriate), one or more of the student's current teachers and a school district representative.

NAME (typed or printed)	POSITION (typed or printed)
_____	Parent
_____	Parent
_____	Student*
_____	Teacher of _____
_____	Teacher of _____
_____	Teacher of _____
_____	Teacher of _____
_____	School District Representative (Chairperson)
_____	_____
_____	_____

*The student may participate if the parents choose to have the student participate.

II. GOALS AND OUTCOMES: (Use as many copies of these pages or sections of these pages as needed to plan appropriately for the student).

A. ANNUAL GOAL:

B SHORT-TERM LEARNING OUTCOMES:

1) Short Term Learning Outcome:

- Objective Criteria –
- Assessment Procedures –
- Timelines -

2) Short Term Learning Outcome:

- Objective Criteria –
- Assessment Procedures –
- Timelines –

3) Short Term Learning Outcome:

- Objective Criteria –
- Assessment Procedures –
- Timelines –

C. SPECIALLY DESIGNED INSTRUCTION TO BE PROVIDED TO THE STUDENT. (This may be listed with each short-term learning objective or listed in this section.)

D. SUPPORT SERVICES NEEDED TO ENSURE THE STUDENT BENEFITS FROM OR GAINS ACCESS TO A GIFTED EDUCATION PROGRAM.

II. DATES

A. Projected date when services and programs will begin: ____/____/____
Mo Day Yr

B. Anticipated duration of services and programs: ____/____/____
Mo Day Yr