Charlevoix-Emmet Intermediate School District
Multidisciplinary Evaluation Team (MET) Summary

# Traumatic Brain Injury (TBI)

Student _____ Birthdate _____ School _____ Date of MET/IEP _____

Type of Evaluation: ☐ Initial ☐ Reevaluation to determine absence or presence of a disability

BASIS FOR MAKING RECOMMENDATIONS:

| True | False | | |
|---|---|---|---|
| ☐ | ☐ | 1. | Student has an acquired injury to the brain caused by an external physical force resulting in:<br>☐ Total or partial functional disability and/or<br>☐ Psychosocial impairment |
| ☐ | ☐ | 2. | Student has an open or closed head injury resulting in impairment in one or more of the following areas:<br>☐ Cognition ☐ Behavior<br>☐ Language ☐ Physical Functions<br>☐ Memory ☐ Information Processing<br>☐ Attention ☐ Speech<br>☐ Reasoning |
| ☐ | ☐ | 3. | The injury is not congenital or degenerative and was not induced by birth trauma. |
| ☐ | ☐ | 4. | The student has been assessed in all areas related to the suspected disability including, if appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status and motor abilities. |
| ☐ | ☐ | 5. | Suspected disability is not due to limited English proficiency or lack of appropriate instruction in math or reading. |
| ☐ | ☐ | 6. | The findings are not primarily the result of: visual, hearing impairment; emotional impairment; environmental, cultural or economic disadvantage. |
| ☐ | ☐ | 7. | Evidence exists that there is an adverse affect on the student's educational performance. |

The undersigned multidisciplinary team members certify that this report reflects the conclusions reached regarding this student. Any team members who disagree with any portion of the above findings will attach a Minority Report to this copy. All reports needed to verify these findings are attached. These findings will be presented at an IEPT meeting. Results of this report will be shared with parents prior to the IEPT meeting by: _____

REQUIRED SIGNATURE: _____ Family Physician or other approved physician (see attached report)

REQUIRED SIGNATURE: _____ Other specialist who has knowledge of the suspected disability

OPTIONAL SIGNATURE: _____ Other

☐ Minority Report Available

DISTRIBUTION: Char-Em ISD, Local District for CA 60, Parents SE-F-11-06-TBI