

**NASSAU COUNTY DEPARTMENT OF HEALTH  
OFFICE OF CHILDREN WITH SPECIAL NEEDS  
PROGRESS REPORT**

Child's Name: \_\_\_\_\_ Auth. # \_\_\_\_\_ DOB: \_\_\_\_\_  
IFSP Period: From: \_\_\_\_\_ To: \_\_\_\_\_ Agency Name (if  
applicable): \_\_\_\_\_  
Name of Provider: \_\_\_\_\_ Discipline: \_\_\_\_\_  
Name of EIOD: \_\_\_\_\_ Name of OSC: \_\_\_\_\_

Date you started working with this child: \_\_\_\_\_ Frequency/Duration: \_\_\_\_\_  
Where have services been delivered? \_\_\_\_\_  
Number of units authorized: \_\_\_\_\_ Number of units utilized: \_\_\_\_\_  
Number of units not utilized due to:  
Child illness/family vacation: \_\_\_\_\_ Therapist illness/scheduling: \_\_\_\_\_  
Has a parent/caregiver been present for the sessions? If not, how have you communicated with the  
family?

**IFSP FUNCTIONAL OUTCOMES** (For each outcome, rate the progress in this time period: NP-No Progress; LP – Limited Progress; GP – Good Progress; OA – Outcome Achieved. Also include short-term objectives that are being worked on to achieve IFSP functional outcome.):

Describe the strategies the family/caregiver have been taught to use to achieve each outcome and how these strategies are being incorporated into the child's daily routines (e.g. mealtime, bath time, circle time, snack time etc.) Which family member(s) / caregiver(s) have you been working with? (For center-based services identify how you are communicating strategies for carryover.)

**NASSAU COUNTY EARLY INTERVENTION PROGRESS REPORT**

**Child's Name:** \_\_\_\_\_ **IFSP from** \_\_\_\_\_ **to** \_\_\_\_\_

In addition to working with the family, describe all collaborative efforts made to address the IFSP outcomes of this child. Examples: Interactions with medical providers, other EI providers, day care staff, other caregivers, community resources (if other than IFSP team, written consent is necessary)

Please provide an assessment of the child's current level of functioning and progress made towards achieving outcomes. This ongoing assessment can include standardized testing, observations from the IFSP team, clinical opinion and professional judgment.

Recommendations of provider or IFSP team: Include information which supports this recommendation.

I certify that I have received and reviewed a copy of the child's IFSP prior to starting services, have provided services in accordance with the IFSP service's specified frequency and duration and have worked towards addressing the relevant IFSP outcomes. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of Provider completing report: \_\_\_\_\_ Date: \_\_\_\_\_

Discipline: \_\_\_\_\_ Cell phone # \_\_\_\_\_ License # \_\_\_\_\_

Signature of Supervisor/Reviewer: \_\_\_\_\_