**WALTER MAGINNIS HIGH SCHOOL**

1079 Highway 292 Red Wing, Minnesota 55066-2833

Telephone: 651-267-3639 Facsimile: 651-385-6425

Student Name       Grade       Primary Disability

Resident School District       Primary Family Contact

Reintegration Process Start Date       Anticipated Release Date

Post-release Address

Reintegration Plan Key Contact       Title

Phone No.       Email

Planning Team Meeting Dates

Reintegration Planning Team Members:

Name Relationship/Title Agency Phone No. Email

      Student N/A

Reintegration Framework Check List

 Date Staff Initial

[ ]  Planning team established

[ ]  Releases of information signed

[ ]  Decision-making protocol established

[ ]  Student Pre-Transition Inventory completed

[ ]  Family Pre-Transition Inventory completed

[ ]  Supporting life skills plan developed

 Skill Completed Addnl Trng Needed N/A

 Social Skills [ ]  [ ]  [ ]

 Independent Skills [ ]  [ ]  [ ]  Parenting Skills [ ]  [ ]  [ ]  Chemical Health Skill Development [ ]  [ ]  [ ]

 Mental Health Skill Development [ ]  [ ]  [ ]

 Transition Skills [ ]  [ ]  [ ]

 Other       [ ]  [ ]  [ ]

[ ]  Special reintegration considerations (i.e. receiving school calendar, impending family changes, etc)

[ ]  Receiving school primary contact established

 Name       Position

 Phone       Email

[ ]  Student provided with assistance to complete

 reintegration project

[ ]  Primary contact or designee invited to visit student

 at WMHS

[ ]  Re-entry plan developed

[ ]  All school records transferred to next school of

 enrollment

[ ]  Aftercare conditions established

[ ]  Pre-release visit & admission interview scheduled

 School Contact       Phone No.       Date

[ ]  Reintegration plan embedded into IEP

 Date approved

[ ]  Receiving school schedule completed

[ ]  School counselor meeting scheduled

 Name       Date

Administrative Review:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director of Special Education Date

[ ]  Post release follow-up with student

 Date       Method       Result

 Date       Method       Result

 Date       Method       Result

 Date       Method       Result

 Date       Method       Result

 Date       Method       Result

[ ]  Post release follow-up with receiving school staff

 Date       Method       Result

 Date       Method       Result

 Date       Method       Result

 Date       Method       Result

 Date       Method       Result

 Date       Method       Result

90-Day Status Check:

Completed by       Method       Date

Student placement recommendation:

[ ]  District High School [ ]  Special Education Transition Program

[ ]  On-line School [ ]  ALC

[ ]  Special Education Program [ ]  Other (please specify)

Family placement recommendation:

[ ]  District High School [ ]  Special Education Transition Program

[ ]  On-line School [ ]  ALC

[ ]  Special Education Program [ ]  Other (please specify)

Team placement recommendation:

[ ]  District High School [ ]  Special Education Transition Program

[ ]  On-line School [ ]  ALC

[ ]  Special Education Program [ ]  Other (please specify)

Did the team recommend the most integrated setting? [ ]  Yes [ ]  No

If no, why?

Does the student’s current educational placement match the team’s recommendation? [ ]  Yes [ ]  No

If no, reason: [ ] Graduated

 [ ] Moved

 [ ] Transferred due to behavior

 [ ] Returned to secure placement/reoffended

 [ ] Transferred to a more restrictive setting

 [ ] Transferred to a less restrictive setting

 [ ] Inpatient treatment

 [ ] Dropped out

 [ ] Other Explain:

If staff was not able to complete the 90-day status check, why not?

Notes: