Suffolk County Department of Health Services
Division of Services for Children with Special Needs

Special Education Preschool Program
RELATED SERVICE
Quarterly Progress Report -SUMMER

Name of Student: _____ Student's Date of Birth: _____

Date of Report: _____ Chronological Age of Student : _____

Related Service: _____ Related Service Provider: _____

School District: _____ Agency Name: **Up Wee Grow, Inc**.

Total Units Authorized: _____ Total Units Used: _____ Total Units Missed

Goal(s)/Objective(s):

Summary of Progress toward Goal(s) and Objective(s):

Conclusions and Recommendations:

_____	_____	_____
Date	**Signature of Related Service Provider**	**Title and License #**

( ) I confirm that a copy was given to the parent