Shasta Head Start Child Development, Inc.

INDIVIDUAL TRANSITION PLAN

Check Applicable boxes:		
☐ 2 ½ year (30 months)	☐ During School Year, also includes →	☐ Notification of Family Transition form
	☐ End of Year, also includes →	☐ Transition Packet (Kindergarten)

Date: ______________________ Parent/Guardian Name: ______________________

Child's Name:______________________ Birth Date:______________________

Primary Language: ______________________

Transitioning From: ______________________ Transitioning To: ______________________

Family Profile and Goals

Summary of Child's Strengths & Development

Summary of Child's Social Emotional & Health Status

Ideas for Easing Transition
Routines/Rituals:
Familiar Objects:
Favorite Activities/Songs:

Action Plan/Timeline for Transition Activities		
Parents will…	Staff will…	When?

Signature of Attendance

1. ______________________ Parent/Guardian

3.______________________ Staff Member

2. ______________________

4.______________________

I.T.P. Completed at: ☐ ***Meeting (preferable)** ☐ **Home Visit** ☐ **Conference**

☐ **ChildPlus data entry**