

INDIVIDUAL TRANSITION PLAN

Check Applicable boxes:

<input type="checkbox"/> 2 1/2 year (30 months)	<input type="checkbox"/> During School Year, also includes →	<input type="checkbox"/> Notification of Family Transition form
	<input type="checkbox"/> End of Year, also includes →	<input type="checkbox"/> Transition Packet (Kindergarten)

Date: _____ Parent/Guardian Name: _____

Child's Name: _____ Birth Date: _____ Primary Language: _____

Transitioning From: _____ Transitioning To: _____

Program Rollover: 1st Choice: _____ 2nd Choice: _____

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