SHASTA HEAD START CHILD DEVELOPMENT, INC.

CHILD STUDY TEAM – PLAN OF ACTION

Child Name: _____ Age: _____ Date: _____

Center: _____ FW/HV: _____

PLAN OF ACTION

Action Steps-(Include at least one strategy to Prevent, Teach & Reinforce)	**Person Responsible**	**Timeframe**
Next Meeting		

Signatures

Disabilities and Mental Health Department	Site Supervisor
Disabilities and Mental Health Department	Education Staff
Parent/Guardian	Education Staff
Parent/Guardian	Participant
Social Service Staff	Participant