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: _____

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. _____ 3._____
Parent/Guardian Staff Member

2. _____ 4._____

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

☐ ChildPlus data entry