



**GUIDELINES FOR
EARLY CHILDHOOD TRANSITION TO SCHOOL
FOR CHILDREN WITH SPECIAL NEEDS**

EARLY YEARS TRANSITION PLANNING INVENTORY

(To be completed for students with special needs, by parents and/or preschool/sending agencies, prior to initial transition planning meeting.)

Child Information

Name: _____

Date of birth (yy-mm-dd): _____

Address: _____

Postal Code: _____ Phone: _____

Parent(s): _____

Phone (Home): _____ Phone (Work): _____

Home School/School Division: _____

Form Completed by: _____

Date Completed _____ School entry target date _____

* Please refer to Guidelines for School Registration of Students in Care of Child Welfare Agencies, if appropriate.

Needs Inventory

Check the most appropriate item(s). Elaborate if necessary.

HEALTH CARE NEEDS

- () No health care intervention required.
- () Requires assistance to perform specific health care interventions during school hours; please describe _____

- () Requires one or more of the following health care routines performed by a non-health care professional who receives training and monitoring by a registered nurse (Unified Referral Intake System [URIS] Group B)
- ___ Clean, intermittent catheterization
 - ___ Gastronomy care and feeding and medication
 - ___ Emptying an ostomy bag and/or changing an established appliance
 - ___ Suctioning (oral and nasal)
 - ___ Responding to seizures when specific skills are required
 - ___ Assistance with blood glucose monitoring requiring specific action based on results
 - ___ Responding to low blood sugar emergencies
 - ___ Administration of pre-set oxygen
 - ___ Administration of adrenaline auto-injector
 - ___ Other health care routines required by the child and approved by URIS
- () Requires complex medical procedures that must be performed by a registered nurse when apart form his/her family/caregivers (URIS Group A)
- ___ Ventilator care
 - ___ Tracheostomy care
 - ___ Suctioning (tracheal/pharyngeal)
 - ___ Nasogastric tube care and /or feeding
 - ___ Complex administration of medication (i.e., via infusion pump, nasogastric tube or injection (other than auto-injector)
 - ___ Central or peripheral venous line intervention
 - ___ Other clinical interventions requiring judgements and decision making by a medical or nursing professional

SENSORY

Hearing

- Normal
- Deaf or hard of hearing
- Other; please describe _____

Environmental adaptation(s) (safety issues, equipment, materials, etc.) _____

Vision

- Normal
- Low
- Glasses required
- Legal blindness

Environmental adaptation(s) (safety issues, equipment, materials, etc.) _____

MOBILITY

- Independent
- Independent with aids (e.g. walker, canes)
- Mobile with aids; needs help on stairs, play structure, etc.
- Mobile with aids under constant supervision
- Independent wheelchair user
- Wheelchair user, needs assistance (please specify) _____

- Floor mobility only (e.g. hitching, rolling, crawling)
- Fully dependent for mobility

Environmental adaptation(s) (safety issues, equipment, materials, etc.) _____

FINE MOTOR OR PERCEPTUAL MOTOR SKILLS

- () Good fine motor skills
- () Verbal guidance needed to make use of materials; some adaptation of materials needed
- () Active guidance needed to use materials, limited coordination of fine motor skills
- () Intensive guidance and repetition needed
- () Incapable of many fine motor activities

Environmental adaptation(s) (safety issues, equipment, materials, etc.) _____

PSYCHOLOGICAL, EMOTIONAL AND COGNITIVE SKILLS

Attention and Concentration Skills

- () Able to independently engage in tasks for reasonable time with good concentration.
- () Verbal guidance needed to engage in tasks
- () Active guidance needed to develop interest in tasks; difficulty focusing on activities
- () Short attention span; severely limited in ability to focus on an activity or task

Comments _____

Communication Skills

- () Adequate receptive and expressive language skills
- () Adequate receptive language but delayed expressive language
- () Delayed receptive and expressive language
- () Little or no expressive language but some receptive skills
- () Severe communication disorder (receptive and expressive) - needs multi-modal approach and direct assistance to communicate

Environmental adaptation(s) _____

Cognitive Skills

- () Above average cognitive skills
- () Average cognitive skills
- () Mild delay; some difficulty learning new skills; guidance and repetition needed
- () Substantial delay in all areas; difficulty learning new skills; guidance and supervision needed
- () Severely limited ability to learn and much repetition needed

Comments _____

INDEPENDENCE AND ADAPTIVE SKILLS

Toileting

- () Fully independent
 - () Supervision required: please describe _____
-

- () Assistance required: please describe _____
-

- () Diapered _____

Environmental adaptation(s) _____

Dressing

- () Fully independent
- () Verbal reminders and/or guidance required
- () Periodic or partial assistance required
- () Fully dependent

Environmental adaptation(s) _____

Eating

- Independent
- Verbal reminders and/or guidance required
- Learning to eat; guidance and monitoring needed
- Constant supervision needed to ensure physical safety
- Needs to be fed
- Tube fed

Environmental Adaptation(s) _____

Transitions (ability to change activities)

- Changes handled easily
- Verbal cueing required
- Some behavioral reactions; adjustment period needed
- Severe difficulty with transitions

Describe _____

Ability to Play

- Plays with other children
- Prefers to play alone; can play if guided to join activity
- Unable to play with other children; becomes easily overwhelmed or aggressive
- Does not interact with toys or objects

Environmental adaptation(s) _____

Social Skills

- Age-appropriate social skills
- Needs help to plan and structure free play; needs guidance to be socially appropriate; responds to verbal prompting
- Active intervention needed for turn-taking, sharing; intervention required due to withdrawn behavior
- Difficulty responding to limits; aggressive to self or others; often refuses to comply; very isolated from other children

Environmental adaptation(s) _____

Required Supports

Adaptations and/or equipment currently used at home and/or in preschool environment.

Pertinent Diagnostic Information

<i>Diagnosis/Results of Assessment</i>	<i>Professional</i>	<i>Date</i>

Services the Child is Currently Receiving/Attending

Family Physician: _____ Phone: _____

Address: _____ Postal Code: _____

Speech Language Clinician: _____

Agency: _____ Phone: _____

Address: _____ Postal Code: _____

Occupational Therapist (OT): _____

Agency: _____ Phone: _____

Address: _____ Postal Code: _____

Physiotherapist (PT): _____

Agency: _____ Phone: _____

Address: _____ Postal Code: _____

Day Care/Nursery School/Family Day Care: _____

Supervisor: _____ Phone: _____

Address: _____ Postal Code: _____

Child Day Care Behaviour Specialist: _____

Agency: _____ Phone: _____

Address: _____ Postal Code: _____

EARLY YEARS TRANSITION PLANNING INVENTORY
AUTHORIZATION OF EXCHANGE OF INFORMATION

I authorize

(sending name or agency)

(sending name or agency)

(sending name or agency)

to exchange written information concerning:

Name: _____

Birthdate: _____

with _____

(school division)

Parent/Guardian name (please print): _____

Signature: _____

Witnessed by: _____

When completed, please send to the appropriate school division.

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*TRANSITION ACTION PLAN
(sample)*

Student: _____

Date: _____

Summary of Needs (What do we know?)	Information Required (What do we need to know?)	Actions (What do we need to do?)	Roles and Responsibilities (Who will do it?)