|  |
| --- |
| Student Name: Click here to enter text.  |
| DOB:Click here to enter text. |
| Language of Instruction: Click here to enter text. |
| Primary Provider: Click here to enter text. |
| Provider Contact Information: Click here to enter text. Date Transition Report was Completed: Click here to enter text. Assessment Tool Used: Click here to enter text.  |
| **Current Functioning:**  |
| **Strengths:** | **Anticipated strategies needed to successfully access the learning environment:** |
| Transitions, following routines, etc.: |
| Click here to enter text. | Click here to enter text. |
| Social/Emotional/Behavior: |
| Click here to enter text. | Click here to enter text. |
| Pre-Academic Skills:  |
| Click here to enter text. | Click here to enter text. |
| Speech/Language: |
| Click here to enter text. | Click here to enter text. |
| Fine and Gross Motor: |
| Click here to enter text. | Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| **Exit Rating** | **Rating**  | **New Skills or Behaviors** |
| Positive Social Emotional Skills: Click here to enter text. | Choose an item. | Choose an item. |
| Acquiring and Using Knowledge and Skills: Click here to enter text. | Choose an item. | Choose an item. |
| Taking Appropriate Action to Meet Needs: Click here to enter text. | Choose an item. | Choose an item. |
| **Developmental Delay** Is the child demonstrating a delay in any of the 5 areas of development?   | **Yes or No** Click here to enter text.  | **Which area(s)?** Click here to enter text.  |
| **Health Concerns** (allergies, medical needs, diapering): Indicate needs and impact of the student’s health needs. Click here to enter text. | Safety Concerns: Click here to enter text. |
| Parent Input: What information would you like the Child Find team to know about your child? Click here to enter text. |