



Intermediate School District 917 Supplemental Transition Plan Form

This checklist is for 917 staff use only to facilitate the gathering of as much information as possible to prepare and promote as successful a transition for the learner as possible. This form is not intended for parents or local district staff distribution.

Student Name _____ Date _____

Current Program Location: _____

Transition Program Location: _____

The following have been received or completed:

- | | | |
|--|---|--|
| <input type="checkbox"/> Referral | <input type="checkbox"/> Current IEP | <input type="checkbox"/> Current Evaluation Summary Report |
| <input type="checkbox"/> Assistant Director review of paperwork | | <input type="checkbox"/> Site visit arranged
(Evaluation & IEP needed prior to visit) |
| <input type="checkbox"/> Staff discussion regarding student IEP & assessment | <input type="checkbox"/> Space determined | |

Comments _____

Assistive Technology Needs

- Uses assistive technology No assistive technology needs

Comments _____

Classroom/School Supports

- | | |
|---|---|
| <input type="checkbox"/> Can work in small groups | <input type="checkbox"/> Can transition within the building/between classes independently |
| <input type="checkbox"/> Can participate with itinerant service | <input type="checkbox"/> Can work independently |
| <input type="checkbox"/> Can participate in DAPE | <input type="checkbox"/> Can go to lunch/transition |
| <input type="checkbox"/> Can be at recess | <input type="checkbox"/> Can be in a room with others/peers |
| <input type="checkbox"/> Other | <input type="checkbox"/> Other |

Comments _____

Communication- Expressive

- What is student's primary mode of communication?
- | | |
|--|--|
| <input type="checkbox"/> Verbal | <input type="checkbox"/> Verbal paired with symbol system and/or gestures/sign |
| <input type="checkbox"/> Non-verbal uses voice output device | <input type="checkbox"/> Non-verbal uses symbol system and/or gestures/sign |
| <input type="checkbox"/> Non-verbal | |
- Communication Level
- | | | | | |
|--|--------------------------------------|--|-----------------------------------|---|
| <input type="checkbox"/> Echolalic | <input type="checkbox"/> Single word | <input type="checkbox"/> Phrase | <input type="checkbox"/> Sentence | <input type="checkbox"/> Conversational |
| <input type="checkbox"/> Initiates communication | | <input type="checkbox"/> Communicate basic needs/wants | | |

Comments _____

Supplemental Transition Plan Form

Communication- Receptive

- | | | |
|---|--|--|
| <input type="checkbox"/> Responds to yes/no questions | <input type="checkbox"/> Responds to his/her name | |
| <input type="checkbox"/> Responds to routine commands | <input type="checkbox"/> Uses visual or tactile cues to facilitate comprehension | |
| <input type="checkbox"/> Answers wh-questions | <input type="checkbox"/> Requires extended time to process information | |
| <input type="checkbox"/> Complete directions: | | |
| <input type="checkbox"/> 1-Step | <input type="checkbox"/> 2-Step | <input type="checkbox"/> 3-Step |
| <input type="checkbox"/> Independently | <input type="checkbox"/> With prompts | <input type="checkbox"/> Hand-over-hand assistance |

Comments _____

Environmental Adaptations

- | | | |
|---|--|--|
| <input type="checkbox"/> Background music | <input type="checkbox"/> Noise reduction headphones | <input type="checkbox"/> Modify temperature |
| <input type="checkbox"/> Limited visual distraction | <input type="checkbox"/> Light filters | <input type="checkbox"/> Study carrel/office |
| <input type="checkbox"/> Color level system | <input type="checkbox"/> Visual supports -words/pictures/symbols | |
| <input type="checkbox"/> Other | <input type="checkbox"/> Other | <input type="checkbox"/> Other |

Comments _____

Food Concerns

- | | | |
|--|--|--|
| <input type="checkbox"/> Diet restrictions | _____ | |
| <input type="checkbox"/> Food Allergies | _____ | |
| <input type="checkbox"/> Uses utensils | <input type="checkbox"/> Uses utensils with assistance | <input type="checkbox"/> Adaptive utensils |
| <input type="checkbox"/> Can manage finger foods | <input type="checkbox"/> Uses glass/cup | <input type="checkbox"/> Uses modified cup/glass |
| <input type="checkbox"/> Water bottle | <input type="checkbox"/> Assistance cutting food | <input type="checkbox"/> Assistance opening packages |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Difficulty Choking | <input type="checkbox"/> Supervision when eating |
| <input type="checkbox"/> Throwing food | <input type="checkbox"/> Takes others food | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Other | <input type="checkbox"/> Other | <input type="checkbox"/> Other |

Comments _____

Instruction

- | | | |
|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Whole class | <input type="checkbox"/> Small group | <input type="checkbox"/> 1:1 instruction needed |
| <input type="checkbox"/> Other | <input type="checkbox"/> Other | <input type="checkbox"/> Other |

Comments _____

Level of Safety

- | | | |
|--|---|---|
| <input type="checkbox"/> Climbs | <input type="checkbox"/> Hides | <input type="checkbox"/> Runs away |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Chokes | <input type="checkbox"/> Bites |
| <input type="checkbox"/> Staff <input type="checkbox"/> Students | <input type="checkbox"/> Self <input type="checkbox"/> Others | <input type="checkbox"/> Self <input type="checkbox"/> Others |
| <input type="checkbox"/> Destroys property | <input type="checkbox"/> Other | <input type="checkbox"/> Other |

Comments _____

Obsessive/Compulsive

- Yes No

Items _____

Themes _____

Comments _____

Supplemental Transition Plan Form

Paraprofessional Support Needed

- Staff/student ratio at previous setting
 1:1 needed
 Other

Comments _____

Schedule

- Duration map Visual Timer Individual to go with them
 First/Then Individual schedule (wall/at desk) Classroom schedule (wall/at desk)
 PECS Symbols/Pictures/Objects Other

Comments _____

Sensory Concerns

- Clothing Lights Auditory
 Smells Tastes Touch
 Visual Other Other

Comments _____

Sensory Tools

- Ball for balance Body sock Brain gym
 Brushing Lotion Fidgets/stress ball
 Music Chewies Heavy work
 Pressure vest Swing Tunnel
 Weighted ball Weighted blanket Weighted vest
 Ankle/wrist weights Other Other

Comments _____

Toileting Skills

- Independent Verbal/visual cues Assistance with cares
 Pull ups Assistance with clothing Toileting schedule
 Incontinence Fecal matter concerns Urinates in inappropriate locations
 Bowel Bladder Other Other

Comments _____

Transportation Routine

- Bus aide (noted in IEP) Seat belt/harness Car seat
 Transfer needs hand-to-hand supervision Transfer needs eye-to-eye supervision

How often does staff get student on/off the bus? _____

Safety concerns _____

Comments _____
