

Kindergarten Transition Planning Tool

Date: _____

Child's Name: _____

Preschool/
Daycare: _____

School for
Kindergarten: _____

Parent/Guardian: _____

Phone: _____



This form is intended to capture the most essential information about your child. It will be used to guide the transition conversation and planning with the school team.



Team Members

Who are the people involved in your child's support team? If you would like us to contact these individuals directly, please complete the **Consent for Exchange of Information** and provide it to your child's school team.

CDC Team _____

Island Health _____

Behavior
Intervention
Team _____

Family Doctor _____

CYSN
Social Worker _____

Pediatrician _____

Other _____



Strengths & Interests:

What does your child enjoy doing?

(e.g. favourite toys/activities)



Medical Needs:

Does your child have any medical needs?

(e.g. allergies, seizures, other known medical conditions etc.)



Vision/Hearing:

Does your child have a vision or hearing loss? Please specify



Safety:

Do you have any concerns around safety at school?

(e.g. running away from peer group/adults, unsafe climbing, choking risk etc.)



Communication:

Does your child need support communicating their needs and wants with others?

(e.g. understanding/using language, English as a second language etc.)



Sensory Preferences:

Does your child have any sensory preferences?

(e.g. discomfort with loud noises or being dirty/wet; strong food preferences etc.)



Social Emotional Needs:

Does your child need support to create friendships or to remain calm in a group setting?



Physical Needs:

Does your child need support in meeting their physical needs?

(e.g. wheelchair transfers, toileting, feeding, etc.)



Equipment Needs

Does your child use any specialized equipment or technology? (e.g. communication device, stander/walker, toileting support, etc.)

