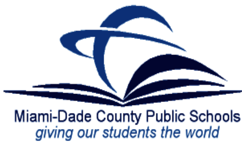
DIVISION OF SPECIAL EDUCATION



PRINT STUDENT'S NAME (LAST) (FIRST) (M.I.)	DATE (MM/DD/YY)	
	STUDENT ID. NO.	

Kindergarten Transition Information
Level B

Likes ...

Dislikes ...

Strengths ...

Basic Info

Child's Name:
Birthdate:
Diagnosis:

Parent's/Family Members:

Address:

Phone #-
Emergency Contact Name & Number:

Pre-K School:
Address:

Phone #-
Pre-K Teacher:

Speech Pathologist:

Physical Therapist:

Occupational Therapist:

Staffing Specialist:

Developed by United Cerebral Palsy of Miami, Inc.

Medical Information

Brief History

Prenatal (pregnancy):

Perinatal (delivery):

3 to 5 years (School attendance, major illnesses, surgeries/procedures):

Current

Medications:

Allergies

_____ Shunt _____ G-tube _____ Tracheostomy/02 _____ Special Diet _____ Hip dislocation/ other deformities	_____ Seizures Type/description: _____ Followed by doctor/clinics List:	Hearing (Observations & Testing results): Vision (Observations & Testing results):

Other concerns:

At School…

Positioning/Equipment

Prone	Prone stander	Walker
Supine	Supine stander	Bench
Sidelying	Freedom stander	Bolster
Long sitting	Tumbleform chair	AFO's
Side sitting	Corner chair	Splints
Ring sitting	Wheelchair	

Other:

Mobility:

Special Precautions:

Communication

Behavior

Self-help/toileting

At Home…

Home Language:

Communication/Behavior:

Equipment:

Family Concerns/Characteristics:

Feeding

Position for Feeding

Special Information/Procedures:

Food Allergies:

Utensils

maroon spoon	bowl
coated spoon	plate
spatula spoon	cutout cup
adapted spoon	spout cup
bottle	handled cup
Other:	

Assistance

fed by adult

hand over hand R L

minimal assistance

independent

other:

Texture

FOODS:	LIQUIDS
pureed	thickened
thickened/lumpy	regular
ground	
chopped	
bite-size	
regular	

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