Transition Plan

Please complete this transition plan and share a copy with the child's parents prior to beginning of the transition visit.

Child Name ______________________________ DOB ______________________

Current Class _____________________ Current Teacher ______________________

Transition Class ___________________ New Teacher _________________________

Time / Date	Time / Date
Monday:	Monday:
Tuesday:	Tuesday:
Wednesday:	Wednesday:
Thursday:	Thursday:
Friday:	Friday:

Important notes and factors to consider while while, supporting the child and family through the classroom transition:

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This visitation schedule is contingent upon space available and ratio being maintained in the transitional classroom. There is a two week proposed transition schedule common, but every child is a unique and a transition needs may vary from child to child. The teacher in administration may need to adapt the schedule based on these needs.

I approve the above information in regards to my child's transition.

Parent Signature: ___________________________________ Date: ________________

Current Teacher: ____________________________________ Date: _______________

Transition Teacher: __________________________________ Date: _______________

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Transition Visit Begins: _________________ Planned Move Date: __________________

Director Signature: ___________________________________ Date:_______________