**Individual Child Transition Summary**

|  |  |
| --- | --- |
| Name Of Child:  | Name of Parent/ Carer: |
| Date Of Birth: |  |
| Current Nursery/Childminder/ Preschool: School:*Including length of time in this setting**Date of Admission* | **Any other previous settings:***Including length of time in these settings**Date of Admission* |
| Child in care: | **Pupil Premium:** |
| Language/s Spoken: | **Likely Travel Arrangements:** |
| Medical Information: | **Number Of Hours Attending Setting:** |

**Further individual Needs:**

|  |  |
| --- | --- |
| Strengths/Achievements/interests: |  |
| Attendance Concerns: |  |
| Sibling Information:  |  |
| Further Consideration/Notes: |  |

|  |  |
| --- | --- |
| Sessions Attended: | Attendance |
| Monday | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | Excellent |
| a.m | a.m | a.m | a.m | a.m | Good |
| p.m | p.m | p.m | p.m | p.m | Below Target |

**Learning**

|  |  |
| --- | --- |
| Two Year Progress Check:Good Progress being madeSome additional support may be neededConcern of developmental delay |  |
| SEN LEVEL:  | **Primary area of Need:**  |

**SEN Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SERVICE | Active  | Historical | N/A | Contact if known: |
| STLS |  |  |  |  |
| Social Services/Early Help  |  |  |  |  |
| SALT |  |  |  |  |
| EP |  |  |  |  |
| Honey Bees |  |  |  |  |
| OT  |  |  |  |  |
| Other |  |  |  |  |

|  |  |
| --- | --- |
| Current Diagnosis: |  |
| Physical Sensory Needs: | Other: |