



Olympic Educational Service District 114 Early Learning Department Kindergarten Transition Plan

Thank you in advance for completing the *voluntary* Kindergarten Transition Summary Form. Completing this form will help the children in your care to have a smoother transition into kindergarten. Research shows that when school districts, early learning programs and parents work together to support children as they enter kindergarten, children experience an easier transition and are more excited about the start of school.

Please complete ONE form for each child transitioning to kindergarten.

Child's Legal Name: _____	
Nickname: _____	
Date of Birth: (mm/dd/yyyy) / /	Circle One: Male Female
Parent/Guardian Name: _____	
Phone: _____	Email: _____

School District Child is Entering: _____

Receiving School: _____

Parent Information:

I, _____ have had an opportunity to review the contents of this form, and understand that the form will be shared with the school district named above for the purpose of kindergarten transition planning.

Parent/Guardian Signature: _____ **Date:** _____

Teacher Information:

I, _____ have clearly communicated the importance of completing this form, the process of kindergarten transition, and the expectations of both the parents, and myself as a teacher to support the child named above.

Teacher Signature: _____ **Date:** _____

Supporting children transitioning to kindergarten is a collaborative effort. Below, we are going to list additional tasks to be completed to strategize a smooth transition.

Action Plan for Staff :	
Task:	Complete by:

Action Plan for Child/Family :	
Task:	Complete by:

Child has an existing IEP: YES / NO

Prior to Kindergarten transition, this child has received the following Early Childhood Education Services:

Services from the OESD 114's Early Learning Department:	Services from another program and/or school district:
Dates Attended: From: _____ Month/ _____ Yr. To: _____ Month/ _____ Yr. Average days per week: Average hrs. per day:	Dates Attended: From: _____ Month/ _____ Yr. To: _____ Month/ _____ Yr. Average days per week: Average hrs. per day: Name of Program: _____ City: _____ Zip: _____
<input type="checkbox"/> Home-visiting (birth to three)	<input type="checkbox"/> District Preschool
<input type="checkbox"/> Early Head Start Services	<input type="checkbox"/> District Developmental Preschool
<input type="checkbox"/> Head Start	<input type="checkbox"/> Licensed Childcare
<input type="checkbox"/> ECEAP	<input type="checkbox"/> Licensed Family Childcare (home based)
	<input type="checkbox"/> Preschool Co-op
	<input type="checkbox"/> Care for by parent/relative
	<input type="checkbox"/> Other

Additional Information:

Please check the box that best describes the child's current ability.

Developmental Domain: Social-Emotional	Most of the time	Sometimes	Not yet	Not sure
Works and plays well with others				
Follows simple directions				
Pauses and gets an adult when there is a problem				
Adapts when what is planned or wanted to do is not possible				
Sticks with an activity for more than a few moments				
Helps, shares, and take turns				

Additional important social-emotional information:

Developmental Domain: Language	Most of the time	Sometimes	Not yet	Not sure
Speech is understood by most people in home language				
Speech is understood by most people in English				

Additional important language information:

Developmental Domain: Literacy	Most of the time	Sometimes	Not yet	Not sure
Recognizes own name in print				
Identifies letters in own name				
Listens to a story being read				

Additional important literacy information:

Developmental Domain: Physical	Most of the time	Sometimes	Not yet	Not sure
Holds pencil with three finger grip				
Can draw lines and shapes				
Sustains balance during simple movement exercises				

Additional important physical information:

Developmental Domain: Math	Most of the time	Sometimes	Not yet	Not sure
Verbally counts to 20				
Counts up to 20 objects				
Identifies basic shapes (square, rectangle, circle, triangle)				

Optional Page

Based on observation and parent input, additional support is needed in:

<input type="checkbox"/> arrival/departure	<input type="checkbox"/> snack	<input type="checkbox"/> center time
<input type="checkbox"/> outdoor time	<input type="checkbox"/> table work	<input type="checkbox"/> toileting
<input type="checkbox"/> large group	<input type="checkbox"/> small group	<input type="checkbox"/> hand washing

About Me (*Capture direct quotes from the child about starting school*)

What are you looking forward to most about kindergarten?

What did you like most about preschool?

About the Child (*comments from parents*)

What do you hope for your child as s/he begins kindergarten?

What do you wonder about kindergarten?

Is there additional information you would like the district and kindergarten teacher to know about this child:

Share a fun story or anecdote about this child that will help their kindergarten teacher better understand this child as a learner.
