TRANSITION INFORMATION SHEET

	Child #1: ________________	Child #2: ____________________	Child #3: ____________________
Medications:	Medication: Dose: Times: Medication: Dose: Times: Medication: Dose: Times: Psychiatrist: ________________ Phone Number:______________ Last Visit: _________ Next Visit: _______	Medication: Dose: Times: Medication: Dose: Times: Medication: Dose: Times: Psychiatrist: ________________ Phone Number:______________ Last Visit: _________ Next Visit: _______	Medication: Dose: Times: Medication: Dose: Times: Medication: Dose: Times: Psychiatrist: ________________ Phone Number:______________ Last Visit: _________ Next Visit: _______
Dietary Needs (lactose intolerance, etc) **Allergies** (foods, pets, seasonal) **Pertinent Medical Information**:	Dietary Needs: Allergies: Other Pertinent Info.:	Dietary Needs: Allergies: Other Pertinent Info.:	Dietary Needs: Allergies: Other Pertinent Info.:
Medicaid Number Medical & Dental Contact:	***Medicaid Number:*** ***Medical Provider:*** Phone: Last Visit: _________ Next Visit: ________ ***Dentist:*** Phone: Last Visit: _________ Next Visit: ________	***Medicaid Number:*** ***Medical Provider:*** Phone: Last Visit: ________ Next Visit: ________ ***Dentist:*** Phone: Last Visit: ________ Next Visit: ________	***Medicaid Number:*** ***Medical Provider:*** Phone: Last Visit: _________ Next Visit: ________ Dentist: Phone: Last Visit: _________ Next Visit: ________
School/Daycare	School /Daycare Attending: ______________________________________ Current Grade Level: _______ Special Services/IEP: _______________________________________	School /Daycare Attending: ______________________________________ Current Grade Level: _______ Special Services/IEP: _______________________________________	School /Daycare Attending: ______________________________________ Current Grade Level: _______ Special Services/IEP: _______________________________________

	Child #1: ________________	Child #2: ___________________	Child #3: ___________________
Behavioral/ Mental Health Needs (temper tantrums, bedwetting, sexualized behaviors, mental health diagnosis, etc..)	Are there any mental health or emotional health concerns/diagnosis? _____________________________________ _____________________________________ _____________________________________ What have you found to be successful in addressing these needs? _____________________________________ _____________________________________ _____________________________________	Are there any mental health or emotional health concerns/diagnosis? _____________________________________ _____________________________________ _____________________________________ What have you found to be successful in addressing these needs? _____________________________________ _____________________________________ _____________________________________	Are there any mental health or emotional health concerns/diagnosis? _____________________________________ _____________________________________ _____________________________________ What have you found to be successful in addressing these needs? _____________________________________ _____________________________________ _____________________________________
Extra-curriculars/ Special Activities	Are there any special activities/sports that the child participates in, which ones? ______________ ______________ What dates/times for upcoming activities should we be aware of? _____________________________ _____________________________ _____________________________ Does this child have a mentor? (Name & Contact Number) _________________________________	Are there any special activities/sports that the child participates in, which ones? ______________ ______________ What dates/times for upcoming activities should we be aware of? _____________________________ _____________________________ _____________________________ Does this child have a mentor? (Name & Contact Number) __________________________________	Are there any special activities/sports that the child participates in, which ones? ______________ ______________ What dates/times for upcoming activities should we be aware of? _____________________________ _____________________________ _____________________________ Does this child have a mentor? (Name & Contact Number) __________________________________
Bedtime Schedule, Rituals & Needs:	Bedtime Night Light? Pull Up? Special Rituals: _____________________________________	Bedtime Night Light? Pull Up? Special Rituals: _____________________________________	Bedtime Night Light? Pull Up? Special Rituals: _____________________________________
Visitation Schedule	Days: ______________ Time:___________ Transportation Arrangement:_________________________	Days: ______________ Time:___________ Transportation Arrangement:_________________________	Days: ______________ Time:___________ Transportation Arrangement:_________________________
Additional Info.			