WEST CENTRAL MINNESOTA
Communities Action

Head Start Behavior Support Plan/ Safety Intervention Plan

Student Name:_____ Date of Birth: _____

Family Education Specialist/Classroom:_____Date:_____

Specialist Working With Child: (e.g. Behavioral Specialist, Physical Therapist): _____

Description of Concerning Behavior(s):

Has a Behavioral Assessment Form been completed and is on file? Yes ☐ No ☐

Is this plan a result of implementing a Safety Intervention Plan? Yes ☐ No ☐

Previous interventions attempted:

Desired positive alternative behaviors/behavioral goals(s):

Alternative staff strategies for classroom implementation/methods for teaching new behaviors:

Parent input/strategies for home-to-school:

Reevaluation/monitoring date:_____

Signatures of attendees:

Name _____ **Title:** _____ **Date:** _____

Name _____ **Title:** _____ **Date:** _____

Name _____ **Title:** _____ **Date:** _____

Name _____ **Title:** _____ **Date:** _____

WEST CENTRAL MINNESOTA
Communities Action

Behavior Support Plan Progress

Student Name:_____ Date of Birth: _____

Family Education Specialist/Classroom:_____Date: _____

Specialist Working with Child (e.g. Behavioral Specialist/Physical Therapist): _____

Description of Concerning Behavior(s):

What interventions have been attempted?

What interventions have been successful?

Child has met the behavior goal(s) of this plan: Yes ☐ No ☐

Next strategies and methods to pursue:

Parent input/strategies for home-to-school:

Reevaluation/monitoring date: _____

Signatures of attendees:

Name:_____ Title:_____ Date:_____

Name:_____ Title:_____ Date:_____

Name:_____ Title:_____ Date:_____

Name:_____ Title:_____ Date:_____