IFSP Individualization Form

Child has Specialized Health Care Plan? ☐ No ☐ YES
If yes, all classroom staff must know the child's plan and receive necessary training.

Child's name: _____ DOB: _____ Classroom: _____

Teachers/Home Visitor/FCCH Provider: _____ Date created: _____

Staff creating this individualization: _____

IFSP Summary

IFSP Begin: _____ IFSP End: _____

CFC #: _____ Service Coordinator (SC): _____ SC Phone: _____

Services **qualified for**: ☐ DT ☐ ST ☐ OT ☐ PT ☐ Other: _____

Services **receiving***: ☐ DT ☐ ST ☐ OT ☐ PT ☐ Other: _____

**Note, if child is not receiving all qualified services, there must be follow up with the CFC until all services are provided.*

Diagnosis (if applicable): _____

Family priorities/concerns from IFSP: _____

IFSP Outcomes - ***What does the family want and why?:***

1. _____

2. _____

3. _____

IFSP Strategies and/or Activities:

1. _____

2. _____

3. _____

Child's interests: _____

Link IFSP outcomes and qualified services to Teaching Strategies Developmeantal Areas and GOLD Objectives

1. Developmental Area: ☐ Social-Emotional ☐ Physical ☐ Language ☐ Cognitive
   TS GOLD Objective related to the IFSP Outcomes & Services:

2. Developmental Area: ☐ Social-Emotional ☐ Physical ☐ Language ☐ Cognitive
   TS GOLD Objective related to the IFSP Outcomes & Services:

3. Developmental Area: ☐ Social-Emotional ☐ Physical ☐ Language ☐ Cognitive
   TS GOLD Objective related to the IFSP Outcomes & Services:

Teachers/FCCH Providers: *use the linked objectives and child's interests to guide individualization, accommodations, & modifications.*
Home Visitors: *use the linked objectives and child's interests to guide individualization through PAT activities.*