Individualized Spiritual Plan

Student name: ______________________________ **School Year**: _________________________

Parent Name(s): ____

Parent Phone Number(s): ____

Parent Email Addresses: ____

Student's DOB: ___________________

Any allergies/medical issues? YES or NO

If yes, please explain:

____

____

My student uses vocal verbal behavior? YES or NO

If my stduent does not talk using his/her voice, does he/she have another form of communication? YES or NO

What is the best way to communicate with your student?

____

____

____

My favorite food is:____.

My favorite thing to do is:____

____

I love it when

____

____

It really bugs me when

____

____.

I am super afraid of

____.

Assessment:

Does your student have a diagnosed disability? If so, what is it?

____

Does he/she take medication? Yes No If so, what does he/she take medication for?

____

Does your child have seizures? Yes No

If so, please plan to provide a seizure care plan for our team.

____

____

Does your student need help with eating or drinking? YES NO

Does your student need help using the restroom: YES NO

Please describe your student's reading level: ________________________________

____

Does your student display any behaviors that might be disruptive in the classroom? YES or NO

If yes, please describe the behaviors:

____

____

What do you do when these behaviors occur?

____

____

Spiritual goal:

What do you want your student to get out of attending SCC?

____

____

____

Please tell us situations where you would absolutely want us to contact you during the service:

____

____

____