

INDIVIDUAL SUPPORT PLAN (ISP)

ELCCC/SAK/SAC

Please circle appropriate program

This Plan must be completed for a child whose cognitive, physical, social, emotional or communicative needs, or whose needs relating to overall development are of such a nature that additional supports are required for the child.

NOT TO BE POSTED

Child's Name: _____ Date of Birth: _____

Family ID#: _____

School Name/Centre: _____

Date Support Plan Completed (dd/mm/yyyy): _____

Date Support Plan Updated (dd/mm/yyyy): _____

Child does not require any additional supports ☐

Diagnosis: Yes ☐ If yes, Please specify _____

No ☐

Child Requires Support with:

Health ☐ Special Needs ☐ Dietary Needs ☐ _____

Safety ☐ Environmental Adaptations (Support Equipment) ☐

STRENGTHS: _____

(Strengths should be developed with input from the child (where possible), parents and Staff.)

Special Instructions:

- Child's personal health information shall be kept confidential.

Child's Name: _____

School Name/Centre: _____

INTERESTS: _____

(Interests to be developed with the help of an interest survey or by interviewing the child and parent.
An interest does not necessarily need to be a strength.)

NEEDS: _____

Instructions, description of supports or aids, adaptations and/or other modifications to the social or learning environment: (if applicable)

Dietary Needs:

Are there any steps to be followed to reduce the risk to the child of any causative agents or situations that may exacerbate the condition or other medical emergency?

Please describe any medical or other devices used by the child and any instructions related to its use:

Child's Name: _____

School Name/Centre: _____

Additional considerations to be followed in an evacuation or off-site field trip:

INDIVIDUAL SAFETY

Safety Concerns

<input type="checkbox"/>	Physical Aggression	Specific Behaviours:
<input type="checkbox"/>	Self-Injurious Behaviour	
<input type="checkbox"/>	Flight Risk	Trigger of Events:
<input type="checkbox"/>	Other	

Critical Proactive Supports

Indicators of Escalation/Anxiety/Agitation	Supportive, proactive interventions:
1.	
2.	
3.	

Escalation Cycle

Observed Behaviour	Staff Response	
Stage 1: Anxiety (Increased Agitation)		
Stage 2: Defensive (Loss of Rational Control)		Contact Head Office to Initiate Emergency Protocol
Stage 3: Acting Out (Unsafe Behaviour)		Contact Parent/Guardian Name: Phone Number:
Stage 4: Tension Reduction		

Child's Name: _____

School Name/Centre: _____

ENVIRONMENTAL ADAPTATIONS

Child requires support with:

Types of equipment/support required:

- | | | |
|---|--|---|
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Walker | <input type="checkbox"/> Stroller |
| <input type="checkbox"/> Hearing aids | <input type="checkbox"/> Leg braces | <input type="checkbox"/> Change table |
| <input type="checkbox"/> Lifts (transfer) | <input type="checkbox"/> Communication devices
e.g. Braille reading materials,
visual products | <input type="checkbox"/> Child uses specific furniture
during floor activities |
| <input type="checkbox"/> Service dog assistance | | |
| <input type="checkbox"/> Other (please list) : | | |

INSTRUCTIONS, DESCRIPTION OF SUPPORTS, AIDS, ADAPTATIONS AND/OR OTHER MODIFICATIONS TO THE PHYSICAL ENVIRONMENT:

GOALS: A maximum of three goals should be decided for the child to work on with staff support in the program

1. _____
2. _____
3. _____

ACTIONS	PERSON(S) RESPONSIBLE FOR THE ACTION	TIMELINES

LOG of PARENT/ STUDENT CONSULTATIONS

Date:

OUTCOMES/NEXT STEPS:

_____	_____
_____	_____
_____	_____

Child's Name: _____

School Name/Centre: _____

REVIEW

PLASP will review the contents of this Support Plan with:

- all regular staff who work at the location every day and relief staff interacting with the child, annually and at any time changes are made to the Individual Support Plan as required by law or due to a change in treatment or condition.
- A record will be kept showing the date of each review conducted, and each record will be signed by each person who conducted or participated in the review.

CONSENT AND PREAUTHORIZATION

I/we agree that it is my/our responsibility to keep PLASP updated and informed with respect to any supports or changes to our/my child's support needs at all times.

I/we agree that it is my/our responsibility to review the Individual Support Plan for our/my child with the PLASP Program Director or Designate at least annually, and at any time that there has been any change to my child's support needs.

I consent to the disclosure of my child's diagnosis (if any) and associated needs and restrictions, in this Individual Support Plan. I further consent to the sharing of the Individual Support Plan with PLASP staff in order that they provide my child with the support set out in the Individual Support Plan.

On _____ (date of meeting) I/we reviewed the Individual Support Plan for our/my child with the PLASP Program Director or Designate at _____ Program/Centre, and have discussed the type(s) of supports that our/my child requires.

I/We hereby authorize PLASP staff to provide support to my child as directed in this plan.

Parent/Guardian Name: (please print) _____

Parent/Guardian Signature: _____
(Day/Month/Year)

Program Director Signature and Date: _____
(Day/Month/Year)

The Area Manager _____ was consulted on _____ regarding this plan.
(Name of Area Manager) (Date consulted)

Date of Annual Review (to be updated and review annually)

(Day/Month//Year)

Child's Name: _____

School Name/Centre: _____

External Staff/Regulated Health Care Professionals consulted regarding this plan and will support the implementation of this plan. (Not for PLASP Staff, Volunteers or Students on Placement)

Name: _____ Date: _____

Title: _____

Name: _____ Date: _____

Title: _____

Name: _____ Date: _____

Title: _____

Name: _____ Date: _____

Title: _____

Name: _____ Date: _____

Title: _____

Name: _____ Date: _____

Title: _____

Name: _____ Date: _____

Title: _____

Name: _____ Date: _____

Title: _____

PROCEDURES FOR COMPLETING THE INDIVIDUAL SUPPORT PLAN (ISP)

Individual Support Plan (ISP)

1. Children who are identified as having special needs are required to have an Individual Support Plan (ISP). This plan is to be completed by the parent/ guardian and staff in the program.
2. When PLASP Staff phone new families to welcome them to the program they are required to make note when children are identified with special needs and to direct the parent/ guardian to visit the program prior to their child starting to complete the necessary Plan.
3. Children identified with safety concerns who experience challenges such as aggression, flight risk, self-injurious behaviours or any other safety related behaviours are required to complete the Individual Safety section of the Individual Support Plan.
4. Children who require special needs equipment to support their participation in the program are required to complete the Environmental Adaptations section of the Individual Support Plan.
5. Staff will meet with the family to discuss the needs/goals for each child that requires an ISP and sign the completed plan.
6. Staff must consult with their Area Manager or the Inclusion Manager to ensure that the needs of the child are being met. The name of the Area Manager and the date such Manager was consulted is to be documented on the plan by the Program Director.
7. Children identified as having special needs that do not require additional support are required to have an **Individual Support Plan (ISP)** completed by checking the appropriate box on the Plan. This plan is to be completed by the parent/guardian and staff in the program.
8. This plan is not posted.
9. (i) The **original of this plan** is to be filed in the Policy Review and individualized Plans for Children Signature Binder and this binder is kept in the SAC program EXCEPT where there is an Early Learning and Child Care Centre at the location under the same license.

(ii) A copy of the plan is filed with the child's registration in the Registration Binder.
10. The plan is to be reviewed and signed by all regular staff who work at the location every day and relief staff interacting with children, annually and at any time changes are made to the Plan as required by law or due to a change in treatment or condition.

Child's Name: _____

School Name/Centre: _____

PLASP INDIVIDUAL SUPPORT PLAN (ISP) REVIEW AND SIGNATURE SHEET

SCHOOL YEAR: _____

This sheet is to be attached to each child's ISP and to be reviewed by all regular staff who work at the location every day and relief staff interacting with the child, to ensure familiarity with the child's plan.

CHILD'S NAME: _____ **SCHOOL NAME:** _____

Program Staff (Print Name)	Signature of Program Staff	Program Director/ Designate (Please Name) Print	Signature of Program Director/Designate	Date