Doña Ana County Head Start
Mental Health/Behavior
Plan of Action

DATE: _____

NAME OF CHILD: _____ CENTER: _____

AGE OF CHILD: ____ PARENT (S) NAME: _____

What were the findings of the Individual Observation?

What are this child's strengths?

What are the parent's concerns regarding their child's behavior/mental health?

Are they seeing the same behaviors at home?

Has this been an issue at other child care settings? If so, how was it handled?

How would parent like to see this concern addressed?

How would the teacher like to see this concern addressed?

Does parent feel a referral to a community resource is necessary at this time?

Does teacher feel a referral to a community resource is necessary at this time?

- ***Objective #1***

_____
_____
_____

TEACHER WILL:

_____
_____

PARENT WILL:

_____
_____

MENTAL HEALTH SPECIALIST WILL:

_____
_____

- **Objective #2**

_____
_____
_____

TEACHER WILL:

_____
_____

PARENT WILL:

_____
_____

MENTAL HEALTH SPECIALIST WILL:

_____
_____

- **Objective #3**

_____
_____
_____

TEACHER WILL:

_____
_____

PARENT WILL:

_____
_____

MENTAL HEALTH SPECIALIST WILL:

_____
_____

By signing this Plan of Action, we agree that we are responsible for completing the above actions in order to assist _____ in adjusting his/her behavior.

We will meet again in _____ to determine whether this plan will need to be modified. The date of our next meeting will be: _____ @ _____.

We will meet at: _____.

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