**targeted support Plan**  (Strategies and Activities)

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| --- | --- | --- | --- |
| **Child’s Name: D.O.B: Date of implementation:** | | | |
| **Child’s Areas to develop** | **Strategies for staff to implement** | **Specific activities to involve child** | **Review after 6-8 weeks** |
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|  |  |  |  |
| **Date of Review: Continue Strategies: Y / N Undertake an I.P.M: Y / N** | | | |

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