Classroom Wellness Action Plan

Child's Name: _____ Teacher: _____

Date	Area of Concern - Teacher Observation or DECA/GOLD Data	Classroom Actions / Strategies	Head Start Staff Initials / Reviewed

Referral for Individual Child Wellness Services

Child's Name _____ Teacher Name_____

Wellness Visits with Campus Counselor, Social Worker or Qualified Interventionist

Specialist Initials: _____

Date of 1st Wellness Visit: _____

Cause of Behavior ☐ Not Observed ☐ Observed with description notes below

_____

_____

Description of Behavior _____

_____

_____

Resolution _____

Signature of Campus Counselor, Social Worker or Qualified Interventionist _____

****

Date of 2nd Wellness Visit: _____

Cause of Behavior ☐ Not Observed ☐ Observed with description notes below

_____

_____

Description of Behavior _____

_____

_____

Resolution _____

Signature of Campus Counselor, Social Worker or Qualified Interventionist _____

****

Date of 3rd Wellness Visit: _____

Cause of Behavior ☐ Not Observed ☐ Observed with description notes below

_____

_____

Description of Behavior _____

_____

_____

Resolution _____

Signature of Campus Counselor, Social Worker or Qualified Interventionist _____

Parent Conferences to Support Individual Child Wellness Services

Child's Name _____

Specialist Initials: _____

Parent Conferences for Wellness Concerns

Date of 1st Parent Conference: _____

Reason for Conference: _____

_____

Outcome: _____

_____

Signature of Parent: _____

Signature of Staff: _____

****

Date of 2nd Parent Conference: _____

Reason for Conference: _____

_____

Outcome: _____

_____

Signature of Parent: _____

Signature of Staff: _____

****

Date of 3rd Parent Conference: _____

Reason for Conference: _____

_____

Outcome: _____

_____

Signature of Parent: _____

Signature of Staff: _____

Resource Agency Support for Individual Child Wellness Services

Child's Name _____

Specialist Initials: _____

Referral to Community Resource

Child was referred to community resource for mental health services, which was facilitated by the mental health professional (campus counselor or Head Start staff).

Date of Referral: _____

Agency Referred To: _____

Outcome: _____

_____

Head Start Staff Signature: _____

****

Referral Verification of Service Provided

Head Start staff contacted parent/guardian to verify if the child was taken to the community resource mental health provider.

Parent Verification: YES _____ NO _____

Head Start Staff Signature: _____

****

Mental Health Assessment

Child was provided an individual health assessment by a mental health professional (campus counselor or community resource agency professional).

Date Referred for Assessment: _____

Referred to: _____

Outcome: _____

_____

Head Start Staff Signature: _____

Individual Child Wellness Services

Child's Name _____

Specialist Initials: _____

Date	Notes