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| **EARLY YEARS SEN SUPPORT PLAN** |

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| **Name of child:** |  | | **Date of birth:** | **Xx/xx/xx** | **Year group/Room:**  **Age in months:** | **Yr X** |
| **Date this plan started:** | |  | | **Date this plan to be reviewed:** |  | |

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| **Agreement of Support Plan** | | | | | | | |
| **Teacher/SENCO signature:** |  | **Date:** |  | **Parent/Carer signature:** |  | **Date:** |  |

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| Aspirations/strengths/interests: | **Preparing for Adulthood Outcomes:** | **Achieved Yes/No** | |
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| **Overview of needs:** | | |

**Education:**

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| **Specific needs** | **What?**  **(including provision & resources)** | **Stage of provision** | **When?**  **(frequency, duration, group size)** | **By Whom?**  **(staffing requirements)** |
| 1. *Eg Cognition and Learning*   *Xxx has difficulty understanding instructions and what is asked of him*  *PLEASE DELETE WHEN COMPLETING* | *1a Adults to break down information presented to him using visual task cards to support processing skills and auditory working memory*  *1b Allow time for Xxx to process instructions* | *additional*  *QFT* | *1a Daily within curriculum sessions as and when required 1:1 30 mins daily*  *1b Daily within curriculum sessions as and when required 1:1* | *TA*  *Teacher/Key worker*  *TA* |
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**Health and or Social Care (delete if not appropriate):**

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| **Specific needs** | **What?**  **(including provision & resources)** | **Stage of provision** | **When?**  **(frequency, duration, group size)** | **By Whom?**  **(staffing requirements)** |
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**Review**

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| **Summary of discussion:** (To include pupil and parent/carer voice) | | | | | **Recommendations of review meeting:** | | | |  |
| **% Attendance:** | | | | | 1. **Support Plan to continue – new outcomes set** | | | | **Y/N** |
| 1. **Support Plan to continue request EY SEND funding** | | | | **Y/N** |
| 1. **EHC Assessment to be requested** | | | | **Y/N** |
| 1. **SEN Support ceases (schools remove from SEN register)** | | | | **Y/N** |
| **Teacher/SENCO signature:** |  | **Date:** |  | **Parent/Carer signature:** | |  | **Date:** |  | |
| **Does the child/young person have an Individual Health Care Plan? yes/no** | | | | **Does the child/young person have a Care Plan/PEP?**  **yes/no** | | | | | |