**Intensive Needs Paraprofessional Support Summary Sheet**

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| Student: | DOB: | Date: |
| Eligibility: | Teacher: | School/Program: |
| Completed by (include title): |  |  |

*Check areas of intensive need that might require additional paraprofessional support:*

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| **Health/Personal Care** | | | | **Behavior** | | |
|  | G-tube feeding\*  Medication\*  Suctioning\*  Food preparation  Diaper changing  Feeding-full support  Seizures\*  Lifting/Transfers  Other: | | | Behavior plan implementation or documentation  Physically aggressive  Non-compliant on campus  Runs away  Self-injurious  Other:  \*Specialized physical health care plan or emergency plan. | | |
| **Area of Need** | | **Is further independence possible?** | **How will independence be encouraged?** | | **How will level of independence be monitored?** | **Are there alternative supplementary aids or services to support this need?** |
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