**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 preparationDiaper changingFeeding-full supportSeizures\*Lifting/TransfersOther:  |  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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