

**CHILD FAMILY SERVICES
NOTIFICATION OF A CHILD SUCCESS TEAM MEETING**

TO PARENTS/GUARDIAN OF _____ DATE: _____
(Child's Name)

COMPLETED BY: _____ POSITION: _____ LOCATION: _____

Service Options:

____ Center Based ____ Home Based ____ FCCH

Your child's Child Success Team Meeting has been scheduled according to your request. We will be discussing your child's development. In making a plan for your child we invite your ideas.

A Child Success Team Meeting to discuss your child's development and to make a plan for your child is scheduled for:

DATE: _____

TIME: _____

PLACE: _____

We anticipate that the following staff members will be in attendance and we encourage you to attend this meeting. Please bring any individual you wish to contribute to this plan for your child.

- | | |
|--|---|
| <input type="checkbox"/> Teacher _____ | <input type="checkbox"/> Program Director _____ |
| <input type="checkbox"/> Child Care Specialist _____ | <input type="checkbox"/> Interpreter _____ |
| <input type="checkbox"/> Nurse _____ | <input type="checkbox"/> Speech/Language Pathologist _____ |
| <input type="checkbox"/> Disabilities Coordinator _____ | <input type="checkbox"/> Mental Health Coordinator _____ |
| <input type="checkbox"/> Site Supervisor _____ | <input type="checkbox"/> Child Development Specialist _____ |
| <input type="checkbox"/> Family Service Worker _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> District/SELPA Representative _____ | |