

The Future Is Now THINK BIG!!!



Taking Steps
Towards
being
Independent

PREPARING FOR TRANSITION PLANNING

FOR PRE-TEENS AND TEENAGERS 7-13 YEARS OLD

How to use this booklet:

Growing up means taking responsibility and this booklet will help you. Go through these questions with help from your parents or an adult family member.

Think about what it means to have a disability and/or special health care need (SHCN) and what you can do on your own. Sometimes learning a new skill takes time and can be frustrating...**don't give up!**

Every step you take will lead to being independent.

Challenge Yourself - Think Big!!!



Self-Advocacy

| | I can do this | Who/what can help me? | Done |
|---|---------------|-----------------------|------|
| Can I say the name of my disability/SHCN? | | | |
| Can I tell others about my disability/SHCN? | | | |

Health & Wellness

| | | | |
|--|--|--|--|
| Do I exercise a couple times a week? | | | |
| Do I wear a helmet when I ride my bike or scooter? | | | |
| Do I eat healthy snacks? | | | |
| Do I brush my teeth two times a day? | | | |
| Have I talked to my parents or doctor about sex? | | | |
| Do I know how my disability/SHCN affects my life? | | | |
| Do I know when I feel sick? | | | |
| Can I name the medicines I take? | | | |
| Can I take my medicine without being reminded? | | | |
| Do I know why I need to take my medicines? | | | |
| Does my disability/SHCN make me feel frustrated/sad? | | | |
| Do I have someone to talk to about how I feel? | | | |

Checklist continued...

Healthcare System

| | I can do this | Who/what can help me? | Done |
|---|---------------|-----------------------|------|
| Do I know the name of my doctor? | | | |
| Do I feel comfortable asking my doctor questions? | | | |
| Do I write down my questions for the doctor before I go see them? | | | |

Social & Recreation

| | | | |
|--|--|--|--|
| Do I have friends I hang out with? | | | |
| Do I know to be safe when using the internet/Facebook to talk to my friends? | | | |
| Have I ever felt like I was bullied? | | | |
| Do I play sports or belong to a club? | | | |

Independent living skills

| | | | |
|---|--|--|--|
| Do I choose my own clothes or activities? | | | |
| Do I take a bath or shower every day and use deodorant? | | | |
| Do I have regular chores? | | | |
| Can I walk/bike alone in my neighborhood? | | | |
| Do I want to drive a car someday? | | | |

School

| | | | |
|--|--|--|--|
| Do I read books for fun? | | | |
| Do I attend my IEP meeting? | | | |
| Do I speak up in my IEP meeting? | | | |
| Do I know how my disability/SHCN will affect me at school? | | | |
| Do I know how to ask for help when I'm at school? | | | |
| Do I share my ideas when working in a group? | | | |
| Have I thought about what I want to do for a job when I grow up? | | | |

What else do I want to know? _____

Notes: _____



Check out the Other Editions in this Series:



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