



Evaluation Information Form Early Learning Center

Student name: _____ Date: _____

Date of birth: _____

Student's town of residence / school district: _____

Name of person completing form: _____

Relationship to student: _____

Medical Information

Birth History

Full term? Yes No If No, gestational age: _____

Complications during or following birth? Yes No

If Yes, please describe: _____

Diagnosis: _____

Additional Medical and Health Conditions

Check all that apply based on medical reports:

- Allergies (be specific): _____
- Cerebral palsy
- Deaf or hearing impaired
- Endocrine disorder
- Feeding problems
- Heart disorder
- Orthopedic impairment
- Seizure disorder / infantile spasms
- Respiratory problems
- Medical device dependent (i.e., g-tube, oxygen, etc.)
- None

Other medical or health conditions: _____

Date of last physical examination: _____

Height: _____ Weight: _____

Hospitalizations / Surgeries (list eye surgeries in vision section which follows):

Seizures

Type: _____

Frequency / Duration: _____

Intensity: _____

Current Medications

Medication	Dose/Route	Time/ Frequency	Reason for Use

Vision Information

Primary visual diagnosis as determined by medical reports:

Blind: Yes No

Light Perception: Yes No

Visual Acuity (if known): Right eye _____ Left eye _____ Both: _____

Does the student use (check all that apply):

- Glasses (prescription and/or sunglasses)
- Prosthesis
- Contact lenses
- None
- Other low vision aids (magnifier, CCTV, telescopes)

Please list other visual aids: _____

Date of last eye exam: _____

Ophthalmologist's name: _____

Visual behaviors (check all that apply):

- Eccentric viewing (head tilt)
- Eye pressing
- Gaze aversion
- Head shaking
- Inconsistent visual performance
- Light gazing (including finger flicking)
- Photophobic (light sensitive)
- Responds to objects only if held close
- None
- Other; please describe: _____

Eye surgeries (please list with date): _____

Hearing Information

Hearing test results:

- Within Normal Limits
- Not Within Normal Limits

If *Not Within Normal Limits*, please indicate type of loss:

- Conductive
- Sensorineural

Degree of hearing loss:

- Mild
- Moderate
- Severe
- Profound

List prescribed aids (i.e., hearing aids, cochlear implants, FM unit): _____

Communication Information

Primary language used by student: _____

- Receptive: Understands functional directions
 Understands multi-step commands
 Within functional limits

- Expressive: Gestures Single words
 Short phrases Sentences

Alternative / Augmentative:

- Objects Pictures
 Sign language Tangible symbols
 Augmentative devices (*switches, computer, Touch 'n Talk, other voice output devices*)

Social-Emotional / Behavior Information

Does the child present any behavioral challenges (for example, tantrums, head banging, aggressive behaviors, difficulties with transitions, difficulties during bedtime or mealtime routines)? Please be as specific as possible. _____

How frequent are any behavioral challenges, and how difficult are they for you to manage? _____

Is there a written behavior plan? _____

Are there any sleep problems? _____

Are there specific events / conditions that cause the child to become upset? _____

How does the child respond to unfamiliar settings and people? _____

What helps to calm the child when he/she is upset? _____

What are the child's most preferred activities? What does he/she typically do during free time? _____

How does the child interact with you? _____

with other adults? _____

with siblings? _____

with other children? _____

Mobility Information

Please check all that apply:

Ambulatory

Long cane

Wheelchair

Alternative cane

Travels stairs

Walker

Does the child use any vision while moving? Yes No

Does the child have any motor limitations? Yes No

Does the child have physical or sensory limitations which impact hand use? _____

How does the child move independently? _____

What types of environments (such as home, school, relatives' homes) is the child exposed to? _____

What motivates the child to move? _____

Do you have specific safety concerns? _____

Additional information: _____

Daily Living Skills

Toileting:

- Toilet trained During the day During the night
- Schedule trained
- Indicates need to be changed
- Needs minor assistance
- Needs total assistance

Comments (include types of potty seats or special equipment): _____

Eating:

- Eats independently (no adaptive equipment)
- Eats independently (may require adaptive equipment)
- Requires intermittent assistance and/or verbal prompts
- Requires significant assistance for safety and/or nutrition
- Food allergies (please list): _____

Diet:

- Regular
- Therapeutic (please specify): _____
- Fed by g-tube

Food consistency:

- Whole Cut-up Soft Chopped
 Pureed Mixed (specify): _____

Does the child use special adaptive mealtime equipment? If so, please list. _____

What type of mealtime seating does the child use?

- Highchair Booster Rifton TrippTrapp
 Other (please specify): _____

Dressing:

- Independent
 Needs some assistance
 Needs total assistance

Adaptive equipment student uses: _____

Additional information: _____

Sensory Motor Integration

How does the child respond to movement activities such as swinging, bouncing, rocking, etc.? _____

How does the child typically respond to touch? Does he/she seem overly sensitive or unaware of touch? _____

Educational Information

Current classroom placement:

- | | |
|---|---|
| <input type="checkbox"/> Fully included | <input type="checkbox"/> Resource room |
| <input type="checkbox"/> Substantially separate classroom | <input type="checkbox"/> Private school |
| <input type="checkbox"/> Home-based services | <input type="checkbox"/> Other |
| <input type="checkbox"/> Early intervention | |

Pre-Braille / Compensatory Skills

Does the child identify common objects? How does the child explore them?

Using his/her mouth, one or two hands? _____

Does the child functionally use toys, writing implements, paintbrushes? _____

Does the child recognize voices and familiar environmental sounds? _____

Does the child enjoy listening to others read stories or rhymes? _____

Listening to audio recordings? _____

Does the child have a favorite book? _____

Does the child hold books and turn its pages? _____

Does the child explore texture books? _____

Does the child explore a variety of textures (smooth, rough, bumpy, wet

scratchy)? If so, does he/she exhibit a preference or aversion to certain

textures? _____

If visual, does the child identify shapes, colors or print letters? _____

Has the child been exposed to braille and if so, does he/she touch braille in

exploration? Does he/she identify any braille letters? _____

Does the child have experience with a braille writer? _____

Support Services

If the child is receiving vision services, who provides them? (Please check all that apply and indicate hours per day / week / month.)

- Certified / Licensed TVI: _____
- Orientation & Mobility Specialist: _____
- Deaf/Blind Specialist: _____
- Other: _____

Does the child receive additional services? (Check all that apply and indicate hours per day / week / month.)

- Individual Aide: _____
- Occupational Therapy: _____
- Orientation & Mobility: _____
- Speech and Language Therapy: _____
- Physical Therapy: _____
- Adaptive Physical Education: _____
- Psychological Services: _____
- Computer Instruction: _____
- Music: _____

Additional information: _____

Has this child been affiliated with any Perkins-related services (for example, Infant/Toddler Program, Outreach, New England Center for Deaf Blind)?

- Yes No

If Yes, please describe. _____

