



Evaluation Information Form

Lower School

Student Name _____ Date _____

Date of Birth _____

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 Devices Dependent (i.e. g-tube, oxygen, etc)
- None

Other Medical or Health Conditions: _____

Date of last physical examination _____

Height _____ Weight _____

Hospitalizations/Surgery (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 student 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 student to become upset? _____

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

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

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

How does the student interact with you? _____

With other adults? _____

With siblings? _____

With other children? _____

Mobility Information

Please check all that applies:

Ambulatory

Long cane

Wheelchair

Alternative cane

Travels stairs

Sighted guide

Walker

Does the student use any vision while moving? Yes No

Does the student have any motor limitations? Yes No

How does the student move independently? _____

What types of environments (such as home, school, relative's homes) is the student exposed to? _____

What motivates the student to move? _____

Do you have specific safety concerns? _____

Additional Information _____

Daily Living Skills

Toileting:

- Toileted trained During daytime? During nighttime?
- Scheduled trained
- Wears diapers, Attends, or pull-ups
- Needs minor assistance
- Needs total assistance

Comments: _____

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 _____

Diet:

- Regular
- Therapeutic (specify) _____
- Fed by G-Tube

Food Consistency:

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

Adaptive equipment _____

Mealtime Seating _____

Dressing

- Independent
 Needs some assistance
 Needs total assistance

Adaptive equipment student uses _____

Additional information _____

Sensory Motor Integration

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

How does the student 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 |

What grade level is the student working at in:

Reading _____
Math _____
Spelling _____
Other Areas _____

Does the student work primarily with:

- Regular print materials
- Large print materials
- Braille materials

Does the student use a braille? Yes No

Does the student have computer skills? Yes No

In what academic areas does the child show the most success? _____

What academic areas are the most challenging? _____

If the student is functioning below kindergarten level, what is the student's estimated developmental level? _____

Does the student identify:

- Objects
- Shapes
- Braille Letters

If visual:

- Pictures
- Colors
- Print Letters

Support Services

If student is receiving VI services, who provides them? (please check all that apply and indicate hours per day, week or month)

- Certified/licensed teacher of students with visual impairments _____
- Orientation & Mobility Specialist _____
- Deaf/Blind Specialist _____
- Other _____

Does the student receive additional services? Check all that apply and indicate hours per day, week or 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 student been affiliated with any Perkins related services? (e.g. Infant/Toddler Program, Outreach, New England Center for Deaf Blind)

Yes No

If yes, describe _____
