



## Evaluation Information Form Lower School

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: \_\_\_\_\_

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Diagnosis: \_\_\_\_\_

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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 student present any behavioral challenges (e.g., 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 students? \_\_\_\_\_

### **Mobility Information**

Please check all that apply:

Ambulatory

Long cane

Wheelchair

Alternative cane

Travels stairs

Walker

Sighted Guide

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, relatives' homes) is the student exposed to? \_\_\_\_\_

What motivates the student to move? \_\_\_\_\_

Do you have specific safety concerns? \_\_\_\_\_

Additional information: \_\_\_\_\_  
\_\_\_\_\_

**Daily Living Skills**

Toileting:

- Toilet trained       During the day       During the night
- Schedule 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 mealtime 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:

- Fully included       Resource room       Private school
- Home-based services       Substantially separate classroom
- Other: \_\_\_\_\_

At what grade level is the student working...

...in Reading: \_\_\_\_\_

...in Math: \_\_\_\_\_

...in Spelling: \_\_\_\_\_

...in other areas: \_\_\_\_\_

Does the student work primarily with materials in:

Regular print

Large print

Braille

Does the student use a braille?

Yes

No

Does the student have computer skills?

Yes

No

In what academic areas does the student 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

\_\_\_\_\_

If the student 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 student 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 student 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. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

