



## Evaluation Information Form Secondary

Student name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Student's town of residence / school district: \_\_\_\_\_

Name of person completing form: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

### Vision

Totally blind:  Yes  No

Partially sighted:  Yes  No

Visual acuity: Right eye \_\_\_\_\_ Left eye \_\_\_\_\_ Both: \_\_\_\_\_

### Hearing

Describe the student's hearing: \_\_\_\_\_

\_\_\_\_\_

List prescribed aids (cochlear implants, FM unit, etc.): \_\_\_\_\_

\_\_\_\_\_

### Speech and Language

Describe the student's receptive and expressive language: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Educational Information**

Type of educational placement: \_\_\_\_\_

Approximate grade level of educational performance: \_\_\_\_\_

Interests, strengths, and areas of difficulty (please describe): \_\_\_\_\_

**Educational Support Services**

Please check all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Individual Aide: _____      | <input type="checkbox"/> Itinerant Vision Teacher: _____      |
| <input type="checkbox"/> Occupational Therapy: _____ | <input type="checkbox"/> Orientation & Mobility: _____        |
| <input type="checkbox"/> Physical Therapy: _____     | <input type="checkbox"/> Speech/Language Therapy: _____       |
| <input type="checkbox"/> Counseling: _____           | <input type="checkbox"/> Psychological Services: _____        |
| <input type="checkbox"/> Adaptive P.E.: _____        | <input type="checkbox"/> Adaptive Computer Instruction: _____ |

**Social Skills**

Describe the student's social skills, relationships, and use of leisure time: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Behavior and Adjustment**

Are there any behavior and adjustment concerns? \_\_\_\_\_

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**Orientation and Mobility**

Describe the student's mobility at school, home, and in the community. Include the use of mobility aids. \_\_\_\_\_

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**Daily Living Skills**

Describe the student's daily living skills, including eating, dressing, toileting, and use of adaptive equipment: \_\_\_\_\_

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**Medical Information**

Diagnoses

Please list all: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies

Please list all: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical History

Please list all surgeries / hospitalizations, including psychiatric hospitalizations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Seizures

Type: \_\_\_\_\_

Frequency / Duration: \_\_\_\_\_

Intensity: \_\_\_\_\_

Current Medications (include seizure medications)

Medication	Dose/Route	Time/ Frequency	Reason for Use

Does the student use any medical devices / equipment (e.g., tracheotomy, oxygen, etc.)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional information including mental health history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

