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: ______________________________________
_________________________________________________________
_________________________________________________________

Did the child spend time in the NICU after birth?  ☐ Yes  ☐ No
If Yes, how long? ____________________________________________

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

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<tr>
<th>Medication</th>
<th>Dose/Route</th>
<th>Time/Frequency</th>
<th>Reason for Use</th>
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## 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 child 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: __________________________________________

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Perkins School for the Blind – Early Learning Center Evaluation Information Form 3
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: _________________________

Please describe how your child communicates: _________________________

Receptive language (used to receive information) (check all that apply):

☐ Speech
☐ Gestures
☐ Body language
☐ Objects
☐ Photographs
☐ Sign language
☐ Facial expressions
☐ Mayer-Johnson pictures
☐ Augmentative communication device

Expressive methods used (check all that apply):

☐ Sounds
☐ Gestures
☐ Body language
☐ Speech
☐ Photographs
☐ Sign language
☐ Objects
☐ Mayer-Johnson pictures
☐ Facial expressions
☐ Augmentative communication device

Length of utterances expressed:

☐ Single words
☐ Short phrases
☐ Sentences

Speech Intelligibility:

☐ Easily understood by others
☐ Not understandable
☐ Understood with some difficulty

Follows directions:

☐ 1-step
☐ 2-step
☐ Multiple-step
☐ Does not follow directions

Pragmatic language (social skills / appropriate use of language):

☐ Makes eye contact / turns toward listener
☐ Waits his/her turn
☐ Says “hello” and “goodbye”
☐ Uses appropriate space boundaries
☐ Initiates conversation
☐ Maintains topic during a conversation
**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 child 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?
____________________________________________________________________

____________________________________________________________________

What are the child’s favorite activities/toys?
____________________________________________________________________

____________________________________________________________________

Educational Information

Current classroom placement:

☐ Fully included  ☐ Resource room
☐ Substantially separate classroom  ☐ Private school
☐ Home-based services  ☐ Other
☐ 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. ________________________________

__________________________________________________
__________________________________________________
__________________________________________________
__________________________________________________
__________________________________________________

__________________________________________________
**Evaluation Questions and Concerns**

Please list the questions you want the evaluators to consider for the evaluation:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________

Please list any additional or more specific concerns: __________________________

________________________________________________________________________

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*Please attach additional paper if needed.*