District 75
400 First Avenue
New York, NY 10010

Assistive Technology Equipment Assessment

Evaluation Information

Parent

Student _____ Date of Birth _____

Address _____

Person Completing Form _____ Date _____

Instructions: Circle or check ALL appropriate answers. Use back of sheet for additional information. Mark N/A for all questions not applicable.

I. Family Information

A. Mother's name _____ Age _____
Address _____
Occupation _____
Home Phone _____ Work Phone _____

B. Father's name _____Age _____
Address _____
Occupation _____
Home Phone _____ Work Phone _____

C. Legal Guardian's name _____ Age _____
Address _____
Occupation _____
Home Phone _____ Work Phone _____

II. Social/Medical Information

A. List doctors and therapists that the child is seeing:
Dr. _____
Address _____

Dr. _____
Address _____

Therapists seen outside of school.

_____

B. List all medications child is taking

_____

_____

C. List all procedures child has undergone.

1. Medical: Date

_____

_____

_____

2. Surgical: Date

_____

_____

_____

3. Dental: Date

_____

_____

D. List all agencies (e.g. social, government or private) with which the family is involved

_____

_____

E. Please attach copies of the most recent medical report for your child.

III. Communication

A. Child's communication method(s):

1. Describe all methods of communication used by your child (communication boards, sign language, etc

_____

_____

2. Does child initiate communication/interaction?
always ___ frequently ___ occasionally ___ seldom ___ never ___

3. Does child respond to communication/interaction?
always ___ frequently ___ occasionally ___ seldom ___ never ___

4. How does child communicate personal needs (i.e., toilet, hunger, pain)?

_____

_____

5. Describe what child does when his first message is not understood.

_____

_____

6. Do you see a discrepancy between what the child understands and what he is able to express to others? Please describe.

_____

_____

_____

_____

7. How does your child interact with familiar adults (i.e., parents, grandparents, etc

_____

_____

_____

_____

8. How does your child interact with family peers or siblings? Describe how they play together, who takes charge, how they communicate, etc.

_____

_____

_____

_____

_____

IV. Environments

A. Outside Home/Community

1. List places your child goes in the community

_____

_____

_____

2. Does your child have the opportunity to visit friends, relatives, etc.? Describe

_____

_____

_____

B. At Home

1. How is your child positioned at home? List any adaptations.

Sitting ____	*Semi-reclined ____*	*On Back____*
On Stomach____	*On Right or Left Side ____*	

2. List all activities child enjoys participating in while at home.

_____
_____
_____
_____

V. Parent Comments

A. Please take time to write about your child's special qualities

_____
_____
_____
_____
_____

B. What do you expect a communication device to enable your child to do that he/she is unable to do with his/her current mode of communications.

_____
_____
_____
_____
_____

Please feel free to send other information you feel would help in the evaluation process.

The above information and all data obtained from various agencies and professionals listed may be used by the evaluation team for the purpose of evaluating your child.

Date _____ Parent or Legal Guardian _____