District 75
400 First Avenue
New York, NY 10010

Assistive Technology Equipment Assessment/D75

IDENTIFYING INFORMATION

Student Name: _____ Evaluation Date: ___/___/___

Date of Birth: ___/___/___ OSIS #: _____ CSE Case #: _____

Parent/Guardian Name:
_____ Primary Language: _____

Parent/Guardian Address: Telephone:
_____ Home: (___) _____
_____ Work: (___) _____

School/Site: _____ Program: _____ Service District: ___75___

School Address: Principal:
_____ _____
_____ Signature: _____

Evaluation Contact Person: Title: Telephone:
_____ _____ (____) _____

Team Members / Service Providers

Teacher			
Paraprofessional	Frequency	Duration	Group Size
Speech & Language			
Physical Therapy			
Occupational Therapy			
Vision Services			
Hearing Services			
Counseling			
Other			

Reason For Evaluation

Augmentative Communication _____ *Computer/Computer Access* _____
Vision _____ *Other-please indicate* _____

BACKGROUND INFORMATION

Student Name: _____ OSIS #: _____

A. List Adaptive/Assistive and Augmentative Communication Equipment available at school:

_____

_____

B. Student's experience with above equipment

_____

_____

_____

• Type of computer(s) in school / home:

_____

_____

• Please list type of software used:

_____

_____

_____

C. Will student be moving from class to class? _____

D. Description of handwriting skills: _____

_____

_____

E. Describe any Physical/Sensory/Perceptual deficits which interfere with accessing a computer or augmentative communication system:

_____

_____

G. Size of print/symbol student is able to read/identify: _____