



## *Input checklist for Occupational Therapy (OT) Services Preschool*

Date: \_\_\_\_\_ Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Student #: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_ School: \_\_\_\_\_

This checklist is intended to help identify areas where students have difficulties that may be addressed by the school Occupational Therapist. Please check of areas of concern or difficulty. Comments are welcome. Please forward to your school Occupational Therapist. Thank you for your help.

### **The student has difficulty: (please check all that apply)**

- Keeping self upright in seat when doing desk/table activities.
- Holding writing utensils and other tools.
- Producing appropriate prewriting marks.
- Working from left to right.
- Using scissors with good coordination and age appropriate accuracy.
- Gathering and putting away classroom materials.
- Eating without spilling.
- Drinking without spilling.
- Eating and drinking within the allotted time.
- Eating without stuffing mouth.
- Acceptance of a variety of foods.
- Choking and/or gagging.
- Wiping and cleaning face.
- Opening beverage containers and utensil packets.
- Managing accessible toilet/sink and paper towel dispenser.
- Washing and drying hands.
- Managing clothing and/or fasteners in the restroom/school environment.
- Opening/closing doors.
- Managing coat, backpack, locker.
- Ability to hold attention to finish a task.
- Building simple block designs.
- Holding objects with fingertips vs. whole hand/palm.
- Maintaining stability when arms unsupported (May demonstrate a tremor/shakiness or knock something over inadvertently.)

**COMMENTS:**