

Input Checklist for Occupational Therapy (OT) and Physical Therapy (PT) Services

Date:	Student Name:	
DOB:	Student #:	Grade:
Teacher:	School:	
by the school occupational therap	ist and/or physical therapist. Ple	ur student has difficulties that may be addressed ease check of areas of concern or difficulty. and/or occupational therapist. Thank you for
☐ Getting in/out of desk. A ☐ Moving around the classr ☐ Moving through the halls ☐ Keeping pace with classn ☐ Walking long distances (t ☐ Moving through congester ☐ Going up or down stairs. ☐ Getting off the bus and/or ☐ Moving on uneven surfact ☐ Opening and closing door ☐ Legible (may not be perfer ☐ Grip on pencil. Handednet ☐ Copying from the chalkbet ☐ Organizing/accessing boothe tasks). ☐ Using the restroom (inclued Managing tray and utensite Eating without spilling. Manipulation of tools (peed Manages coat, backpack, Keeping belongings organt Participating in recess/freed Able to use the playground.	a their desk (feet flat on the floor bility to stay in desk without fid oom (around obstacles, etc.). with the rest of the class. nates when walking. To from playground, lunchroom, and areas (crowded hallways) with the van. The est of the class. nates when walking. To from playground, lunchroom, and areas (crowded hallways) with the van. The est of the class. nates when walking. To from playground, lunchroom, and areas (crowded hallways) with the est of the following states of the play of th	etc.). nout bumping into people/objects. s, etc.). t their desk (consider the time taken to complete

COMMENTS: