

ASSISTIVE TECHNOLOGY CONSIDERATION CHECKLIST

SEDGWICK COUNTY AREA EDUCATIONAL SERVICES INTERLOCAL COOPERATIVE

Student's Name _____ Student's DOB _____ Age _____

Grade level _____ Disability _____ Teacher _____

SLP _____ OT _____ PT _____

School phone number _____ e-mail _____

1. Is the student currently able to independently complete tasks with special strategies or accommodations? Yes or No

If the answer to #1 is yes, then STOP.

If the answer to #1 is no, proceed to question #2.

	Standard classroom Curriculum being successful	Modifications/ Adaptations being successful	Additional help needed, Including assistive technology *
Writing			
Spelling			
Reading			
Math			
Study Skills			
Communication			
Vocational Skills			
Seating & Positioning			
Mobility			
Vision/Hearing			
Pre-K Readiness Skills			

(Respond with Yes, No or NA in appropriate columns)

3. *If any items are checked yes, contact appropriate related service team member for additional recommendations, consultation and/or possible AT evaluation.

General Comments on Assistive Technology

(Only respond to those questions that you feel are appropriate to your student)

1. What are your main concerns about this student?

2. What would you like the student to be able to do that they cannot currently do?

3. Are there any behaviors (both positive and negative) that significantly impact the student's performance?

4. Are there significant factors about the student's strengths, learning style, coping strategies, or interests that the AT Team should consider?

5. Are there any other significant factors about the student that the AT Team should consider? (Such as behavior, motor, medical diagnosis, vision, hearing)
