Clear Form

Appendix 7

Children's TREATMENT CENTRE OF CHATHAM-KENT
Celebrating Abilities, Developing Potential

# SCHOOL BASED REHABILITATION SERVICES
# Occupational Therapy Teacher Checklist

**Student Name:** **DOB:** *(dd/mm/yyyy)* **GoldCare #:**

*** Please check any areas of concern where the student has difficulty meeting curriculum expectations.**

## GENERAL CLASSROOM SKILLS

- ☐ Maintain focus in the presence of distractions
- ☐ Remain seated for class work
- ☐ Follow verbal instructions
- ☐ Follow written instructions
- ☐ Follow classroom rules and routines
- ☐ Transition between tasks

## HANDLE MATERIALS AND MANIPULATIVES

- ☐ Consistent hand preference
- ☐ Functional pencil grasp/pressure (☐ too heavy ☐ too light)
- ☐ Functional scissor grasp and cutting accuracy
- ☐ Adequate pencil control for drawing, tracing, colouring
- ☐ Able to manipulate tools (eraser, math, art/science materials)
- ☐ Assemble puzzles without difficulty
- ☐ Able to draw with age appropriate detail
- ☐ Able to use regular keyboard successfully (if applicable)

## WRITTEN COMMUNICATION

- ☐ Recognizable letter formation & legible printing
- ☐ Complete written work in a timely manner
- ☐ Written output does not hinder academic performance
- ☐ Student consistently receive scribing support or use of technology for written output

## GENERAL ORGANIZATION SKILLS

- ☐ Approaches task in an organized, non impulsive manner
- ☐ Able to keep track of personal belongings
- ☐ Able to organize desk and school materials
- ☐ Able to complete work in a timely manner
- ☐ Able to complete multistep activities as appropriate for age
- ☐ Able to persist when performing a challenging task

## SELF CARE SKILLS

- ☐ Safely access bathroom (and equipment) for toileting
- ☐ Remove/reassemble clothing following toileting
- ☐ Maintain appropriate level of hygiene
- ☐ Put on/remove outdoor clothing
- ☐ Manage fasteners (zippers, buttons, snaps)
- ☐ Open containers for snack/lunch
- ☐ Able to feed self independently during snack/lunch

| |
|---|
| **Do you have concerns regarding vision (ability to read large volume of text/copy from the board)?** ☐ **Yes** ☐ **No** |
| **Does the student have identified challenges with CAP – central auditory processing?** ☐ **Yes** ☐ **No** |
| **Do you have concerns for position/alignment of student's arms/legs/back during rest or activity?** ☐ **Yes** ☐ **No** |

| | |
|---|---|
| **Please comment on student's general classroom performance in the following areas:** | |
| **Academics:** | |
| **Social/Behaviour/Attention:** | |
| **If not listed, describe concern below or provide any additional details:** | |
| **Strengths/Interests:** | |

| | |
|---|---|
| **Teacher:** | **Resource Teacher:** |
| **School:** | **Grade:** |

Completed by Signature

Date

*__Please attach and submit with Principal Referral form__

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