## TEACHER/THERAPIST EVALUATION FORM

Child's name:			Date of Birth:			
School:			Type of school:			
Number of children in class:			Teachers/adults in class:			
Speci	al services/therapies fo	or this chil	ld:			
Pleas	e compare this child de	evelopmen	tally to other cl	nildren his/her age		
(inclu	ding both strengths and	d areas wh	nich require sup	pport):		
Physi	cal Development:					
Α.	General Appearance		Normal	Atypical		
В.	B. Physical Handicaps (describe):					
C.	Sensory Handicaps (describe):					
		Good	Fair	Poor		
D.	Gross motor skills					
E.	Fine motor skills					
F.	Drawing skills					
G.	Comments:					

## Speech and Language

1. Does this child speak English?
2. Is this child bilingual? What language?
3. Does this child understand and use gesture language?
4. Does this child use complete sentences?
5. Does this child use age-appropriate vocabulary?
6. Does this child maintain conversational exchanges?
7. Does the child appear to understand what is said to him?
8. Does the child follow directions only with gestures?
9. Does the child follow directions even without gestures?
Behavior and Affect
Please describe strengths and as well as unusual or atypical behavior:

Social skills (ability to initiate and maintain interactions)

Relationsh	ip to adults			
Relationsh	ip to peers			
Play (abilit	ry to play with oth	ners, imaginative pla	ıy, need for adult sup	ervision, etc)
Self Help (	if appropriate for	age)		
Toileting Feeding Dressing	Completely Dependent	Needs some help	Completely Independent	
Washing				

### **General Comments**

Where is this child most succ	cessful while in the schoo	ol setting?_
Like what age does the child	act?	
Do you feel this child is deve	elopmentally "different" f	rom other children? Why?
Do you feel this child needs	special education support	ts? Why?
Any additional comments?		
Signature:	Title:	Phone:
Nama:	Dato:	

Please feel free to call Dr. Bertin or to expand on the above with further details if it you feel it would be helpful.