# School Checklist

**Student's Name:** _____ **Date:**_____

**Children's behavior and abilities may differ at home and at school. In order to get a more accurate picture of the child and how best to help him or her, please have a teacher that is familiar with your child complete this form.**

Check the appropriate column. Make any comments you feel are pertinent to your student's development.

## Attention/Focusing *Does your student:*

__Yes __No **1.** Have difficulty paying attention when spoken to? *Comments:* ___
__Yes __No **2.** Have trouble sitting still in his/her chair? _____
__Yes __No **3.** Seem to daydream/tune out the person speaking? _____
__Yes __No **4.** Have trouble following multi-step directions? _____
__Yes __No **5.** Seem to have the need for excess movement while in desk, at circle-time, or standing in line? _____
__Yes __No **6**. Rock back and forth when supposed to be sitting still? _____

## Modulation *Does your student:*

__Yes __No **1.** Have difficulty with transitions? *Comments:* ___
__Yes __No **2.** Shut down or have meltdowns? _____
__Yes __No **3.** Seem to be emotionally "up and down"? _____
__Yes __No **4.** Have a low frustration tolerance? _____
__Yes __No **5.** Rock, bang head, hit when frustrated? _____
__Yes __No **6.** Seem overly sensitive to sound? _____
__Yes __No **7.** Like to make loud noises?
__Yes __No **8.** Appear sensitive to light?

## Tactile/Touch Sensation *Does your student:*

*Comments:* _____

__Yes __No **1.** Dislike messy textures? (ie, glue, play-dough) _____
__Yes __No **2.** Dislike getting dirty? _____
__Yes __No **3.** Have negative reactions if touched? _____
__Yes __No **4.** Dislike wearing socks/shoes? _____
__Yes __No **5.** Isolate self from other students? _____
__Yes __No **6.** Bump or push other children? _____
__Yes __No **7.** Avoid certain textures of food?
__Yes __No **8.** Have difficulty standing in a straight line?

## Fine Motor Skills *Does your student:*

__Yes __No **1.** Have trouble manipulating small objects? *Comments:* _____
__Yes __No **2.** Have difficulty holding pencils/crayons? _____
__Yes __No **3.** Have trouble coloring within lines? _____
__Yes __No **4.** Have difficulty with scissor skills? _____
__Yes __No **5.** Have difficulty fastening clothing? _____
__Yes __No **6.** Eat in a sloppy manner? _____

## Gross Motor/Coordination *Does your student:*

__Yes __No **1.** Seem accident prone? *Comments:* _____
__Yes __No **2.** Have difficulty with sports activities? _____
__Yes __No **3.** Tend to just watch other children on playground? _____
__Yes __No **4.** Have difficulty with skipping or jumping jacks? _____

## Visual Skills *Does your student:*

| | | | |
|---|---|---|---|
| __Yes __No | **1.** | Have difficulty eye-tracking? | *Comments:* _____ |
| __Yes __No | **2.** | Make reversals when copying? (after age 7) | _____ |
| __Yes __No | **3.** | Have difficulty discriminating colors, shapes? | _____ |
| __Yes __No | **4.** | Have difficulty copying off the board? | _____ |

## Additional Comments:

Please include any additional information that may be helpful in understanding the student's strengths or difficulties functioning in the classroom.