Occupational Therapy

Student Name: _____ _____ Date: _____ Time: _____
Therapist: _____ School: _____

Your student was seen for Occupational Therapy today. If you would like to talk to me more about your student, I can be contacted at _____

_____

Response to therapy: € Good € Average € Poor € No Response

Activities:	Fine Motor	Self Care/ADL	Motor planning
	Oral Motor	UE Strengthening	Developmental Play
	Oral Desensitization	Visual-Perceptual-motor	Sensory regulation
	Adapt. Equipment	Consult/Instruction	Other:

Observations/Activities:_____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Plan:

_____
_____

Therapist: _____

Parent or care provider Signature: _____