Ontario School District's
Assistive Technology Assessment Plan

Date of Initial AT Meeting: _____

Basic Information:

Student's Name: _____
DOB: _____
Age: _____
Disability: _____
Current Grade: _____

Team Members:

(In addition to the regular IEP Team)

_____
_____
_____
_____

Goal:

What we hope to change with AT (refer to AT wheel): _____
_____
_____

Data Collection:

We will collect data by doing the following: _____
_____
_____

Criteria:

What will show us the AT is (or is not) working?: _____
_____
_____

Environment:

Location where the device will be used (describe environment and tasks):
_____
_____
_____

Implementation:

Person responsible for proper implementation: _____
_____

Specific Devices for Trial

Device #1:

Item: _____

Start: _____ End: _____

Review Dates: _____

Source of Device for Trial: _____

Comments:_____

_____

_____

Device #2:

Item: _____

Start: _____ End: _____

Review Dates: _____

Source of Device for Trial: _____

Comments:_____

_____

_____

Device #3:

Item: _____

Start: _____ End: _____

Review Dates: _____

Source of Device for Trial: _____

Comments: _____

_____

_____

Device Chosen: _____

Advantages: _____

_____

_____

Disadvantages: _____

_____

Student's Thoughts: _____

When will it be used?: _____

Included in the IEP: ☐ Training Completed: ☐ Teachers Notified: ☐