WYOMING NEXT STEP ASSESSMENT CLINIC

**November 2, 2018**

The attached application must be returned by September 10, 2018. Because the Next Step Assessment Clinic can assess a limited number of children during each clinic, applications will be considered in the order in which they are received. School contacts will be notified by September 17th, at the latest, if the student from their school has been accepted.

For students who are accepted to participate in the Clinic, the following information will need to be submitted prior to October 5th. Further information, releases and family/school surveys will be sent to schools with their Clinic acceptance letter.

 **Check/voucher** for $400.00 made out to Wyoming Deaf-Blind Project

* **Student’s Daily Schedule**
* **IEP/IFSP with Goals and Objectives**
* **School Interview Form** – completed by members of the student’s educational team
* **CD /JUMP DRIVE/ or emailed video** – 5-15 minutes in length depicting areas of concern that you are asking the Educational Assessment Team to address during the assessment. This is also an introduction of the student to the team – aiding the team in development of the assessment process.
* If the team has concerns about nutrition, independent eating or other mealtime challenges: **5 minute video** with segments containing the student participating in those areas of concern
* **Family Interview** – completed by family
* Signed **Release of Information**
* **Photo Release**
* Any pertinent **Medical Information** – This information is vital in determining how to assess the student.

If you have any questions, please feel free to contact our office at 307-856-5652 or email me at leslie.vanorman@wyo.gov

Applications should be mailed to:

Leslie Bechtel Van Orman

Wyoming Project for Children and Youth Who Are Deaf-Blind

320 W. Main St.

Riverton, WY 82501

**Wyoming Next Step Assessment Clinic**

 **Wyoming Department of Education**

**November 2, 2018**

# Application is due by September 10, 2018

**(We are able to conduct a limited number of assessments, applications will be processed, as they are received.)**

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| Name of Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student’s weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WISER ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male  Female Name of Parent(s)/Guardian(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School District/ Preschool Region:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_ |

**Check the Areas for Inclusion in the Assessment**

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| Medical Staff | **Nutritional Mealtime****Management Team** | **Educational Assessment Team** |
| AudiologistPsychologist Optometrist |  | Nutritionist/DietitianOccupational TherapistSpeech Language Pathologist **If checked, make sure to fill out the attached Mealtime Management Form** |  | Augmentative Communication SpecialistTeacher of the Deaf/Hard of HearingOccupational Therapist Orientation & Mobility Specialist Physical Therapist Speech/Language Pathologist Teacher for Students with Visual ImpairmentsAssistive Technology |          |

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| **Additional Areas of Focus** |
| Nutritional Mealtime Assessment / StrategiesBehavior Concerns / Strategies |  | Functional Vision Learning Media |  |

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| * Please state your reason for attending the WY Next Step Assessment Clinic
	+ Prioritize the areas of concern (1, 2, 3, 4 etc.)
* What are your expectations?
* Why did you select the appointments and assessments that you did?
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| **Vision Concerns** |
| BlindnessLow VisionLight SensitivityCVIGlasses **(Bring to the Clinic)** |  | Field LossUnsure of VisionVisual Aids used **(If hand held bring to the Clinic)****If you have a current eye exam, please attach it to the clinic application** |  |

List other vision concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Hearing Concerns |
| Unsure of HearingDeafDeaf / Hard of Hearing **If you have a current audiogram, please attach it to the clinic application** |  | Personal Hearing Aid **(Bring To Clinic)**Amplified SystemsClassroom SystemBAHACochlear Implants Right Left  |  |

List other Hearing Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Communication ConcernsCheck all that apply |
| Unsure of Communication MethodVerbal \***(Sounds, Words, Sentences)**Non – Verbal \***(facial, gestures, eye gaze)** |  | Sign LanguageObjects **\*(Pictures, Symbols)**Augmentative Communication |  |

 List equipment being used and if transportable, please bring it to Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List other Communication Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Assistive Technology*Check all that apply* |
| Low Tech Adaptations\*(Communication Boards, Pictures, Schedules/ Calendar Boxes, Eye Gaze Boards, Switches)ComputeriPad |  | High Tech Adaptations\*(Intelitools, Word Predication, Software Voice, Voice Recognition Systems, Voice output Devices, Educational Software) |  |

If using computers please list the software: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List other assistive technology being used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Gross & Fine Motor Concerns*check all that apply*  |
| Non Ambulatory WalksWalks With AssistanceBraces / OrthoticsPostural ConcernsSeating / Positioning **(Stander, Adapted Chair, Side-Lyer, Prone Wedge, Quad Wedge)** |  | Wheelchair **(Date of Purchase \_\_\_\_\_\_\_\_\_\_\_)**Eye-Hand CoordinationSensory Processing / Sensory IntegrationDevelopmental ConcernsO&M **List Devices:** |  |

List other Motor Concerns:

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| Nutritional Concerns*Check all that apply –* **Nutritional Mealtime Management Form (at the end of the application) must be completed.** |
| NutritionalGrowth / Height / WeightSensory IssuesRespiratory |  | Feeding OralTube |  |

List other Nutritional Concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Behavior Concerns** |
| Acting OutToileting |  | Inappropriate Behaviors (list)Challenges with Social Skills |  |

List other Behavioral concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Medications student is currently taking:** |
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Is there anything else that you want the assessment teams to know about the student: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­