Motor Screening

Student:		Grade:	
Class/Teacher Name:		Date:	

- **Completed by classroom teacher for suspected DD motor or SLD.**

1. Summarize your major concerns regarding this student's motor functioning in the school setting.

   ☐ No concerns: **If no concerns, do not complete rest of page.**
   ☐ Concerns:

   _____
   _____
   _____
   _____

2. Describe how motor concerns are interfering with this student's educational performance.

   ☐ No concerns
   ☐ Concerns:

   _____
   _____
   _____
   _____

3. List strategies you have tried and the outcomes of these interventions.

   ☐ No need for intervention
   ☐ Strategies and results:

   _____
   _____
   _____
   _____

4. Check all that apply for this student:

- Trips or falls frequently
- Needs modifications to participate in PE and/or recess activities
- Has difficulty getting on or off school transportation
- Has difficulty moving from place to place in school environment

- Hand dominance is not established (by age 6)
- Unable to functionally communicate (verbally/written/technology)
- Unable to use classroom tools (pencil, scissors, glue, sharpener)

- Has difficulty dressing/undressing self as it relates to school day
- Needs extra assistance managing snack/lunch