HARBOR HAVEN OCCUPATIONAL THERAPY FORM

In lieu of this form, a 2018-2019 school year IEP with OT goals may be submitted.

Child's Name: _____

Child's age as of June 24, 2019: _____

Parents :

This form must be completed if:

1. ***Your child is signed up to receive individual OT at Harbor Haven this summer.***
   and/or
2. ***Your child is age 3-9. All 3-9 year olds attend an included OT group at Harbor Haven once/week.***

This form does not have to be completed if:

1. ***Your child is age 10-15 and is not going to receive individual OT at Harbor Haven.***
2. ***Your child is age 3-9, but does not currently receive OT.***

PARENT COMPLETES (IF APPLICABLE):

My child receives occupational therapy in the following settings. (Check all that apply):

____ Private (at home)
____ Private (at Therapy Center)
____ School based
____ Other

The therapy is done (check all that apply)

____ Individually
____ Small group (2 or more children at the same time)
____ Push In (the therapist goes to relevant activity with the child to facilitate skills)

At Harbor Haven, my child will receive: (Check all that apply)

_____ The included OT group that 3-9 year olds receive as part of their program. (cost included in tuition)
_____ Occupational therapy sessions that have been signed up for with Harbor Haven. (extra cost applies)

This is the way I would like my child to receive his/her occupational therapy at Harbor Haven (check all that apply – complete only if #2 is checked off above.)

_____ Individually
_____ Small group (2 or more children at the same time)
_____ Push In (the therapist goes to relevant activity with the child to facilitate skills)

Permission to provide information:

I herein give permission for_____, an occupational therapist, to
Therapist's name
provide relevant information about my child,_____ for the Harbor Haven
child's name
summer program.

Parent Signature: _____
Date _____

Harbor Haven Occupational Therapy Form

Child's Name: _____ Date: _____
Name of Therapist _____
Location where therapy is delivered _____

To the therapist: The above named student/client of yours will be attending our program this summer and will be receiving occupational therapy services as indicated above. Your input on the following page will greatly aid us in promoting a successful summer experience. Please use information you know about the student/client as well as the IEP goals/objectives (if applicable.) Please feel free to attach any information that would be helpful as well.

Occupational Therapy Check List

Please check off goal areas that are currently being addressed and list strategies/activities you have found to be successful. Use the back of this page or feel free to attach an additional page as needed

	Check	Strategies/Activities
Sensory Processing		
Vestibular		
Proprioception		
Tactile		
Visual		
Auditory		
Oral Motor		
Respiratory		
Other		
Self-Regulation		
Self-Help		
Visual-Perception		
Fine Motor		
Pre-Writing		
Handwriting		
Gross Motor		
Core Strength		
Muscle Tone		
Other		

Please list anything you feel may be critical to this student's success in OT this summer (i.e. sensory diet, food allergies, motivators, signs, etc.). (Use back if additional space is needed)

1._____

2._____

3._____

Please list a few objectives that can be addressed in group therapy. (3-9 year olds)

1._____

2._____

3._____

Please list specific objectives for individual therapy (if applicable)

1._____

2. _____

3. _____

4. _____

Signature _____

Please return form no later than June 1st. (You may scan, fax or mail)