

**Columbia County Schools
Physical Therapy Screening Tool for Teachers**

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|----------------------------|--|----------------------------|--|
| Student: | | Date of Birth: | |
| Date: | | School: | |
| Regular Classroom Teacher: | | Special Education Teacher: | |

In the educational setting, physical therapy is considered related services designed to support the student's achievement of the educational goals and objectives as defined in the IEP. The school district does not provide medical therapy services, but rather educational therapy required for a student to benefit from special education.

Please place a check in the appropriate box for each motor task. If the student is able to perform a task but takes too much time, place a * in the "yes" column.

| Functional Motor Tasks | YES | NO | Not Applicable | Describe Problem: |
|---|-----|----|----------------|-------------------|
| Doors | | | | |
| Can move through open doorways | | | | |
| Can open / close inside doors | | | | |
| Can open / close outside doors | | | | |
| Classrooms | | | | |
| Can sit / position at desk | | | | |
| Can physically access work materials | | | | |
| Can move between areas in the classroom | | | | |
| Hallways | | | | |
| Can move between locations within the school | | | | |
| Can move through crowded hallways | | | | |
| Can walk in line with peers | | | | |
| Lunchroom | | | | |
| Can carry lunch tray | | | | |
| Can sit / position at lunch table | | | | |
| Can move around lunchroom | | | | |
| Restroom | | | | |
| Can move in and out of toilet stall | | | | |
| Can sit or stand to access toilet | | | | |
| Can access sink and paper towels | | | | |
| School Bus | | | | |
| Can walk up and down bus steps | | | | |
| Can sit safely on bus with or without special restraints | | | | |
| Playground / Outside | | | | |
| Can move around on uneven surfaces on the playground | | | | |
| Can play on outdoor equipment | | | | |
| Can negotiate ramps, curbs and steps | | | | |
| Physical Education | | | | |
| Can participate in regular or adaptive physical education | | | | |

| | |
|---|--|
| Describe need or concern related to physical therapy: | |
| | |

Screening Form Completed by: _____ Date: _____

SEND COMPLETED SCREENING FORM TO SPECIAL SERVICES OFFICE

For office use only: PT Evaluation Indicated: yes no PT Initials: _____ Date _____