Wakulla County Schools
Exceptional Student Education
Occupational Therapy Plan of Care

School year:____________________ **IEP Date:** _________ **Plan of Care Date:** _________________
Student Name:___________________ **Grade:**____________ **Birth Date:**_________________
School:_________________________________

Areas of Functional Limitations:

- ☐ Neuromotor
- ☐ Movement Patterns
- ☐ Balance/Equilibrium
- ☐ Strength
- ☐ Sensory/Perception
- ☐ Fine Motor Skills
- ☐ ROM/Orthopedic

Assessment of Current Status: *See present level on attached Annual Goals & Objectives*

Treatment Plan:

- ☐ Switches/Computer Use
- ☐ UE Strengthening
- ☐ Muscle Facilitation
- ☐ Establish Classroom Plan
- ☐ Monitor Classroom Functioning
- ☐ Home Program/Family Training
- ☐ Writing/Pre-Writing
- ☐ Visual/Perceptual Motor Skills
- ☐ UE Weight Bearing/Shifting
- ☐ Grasping Skills
- ☐ Bilateral Skills
- ☐ Coordination with PT/Speech/Vision/Mobility
- ☐ Splinting/Adaptive Equipment
- ☐ School Work/Play Skills/Attending Skills
- ☐ ADL Activities
- ☐ Oral Motor Skills
- ☐ Sensory Processing
- ☐ Other:

Comments:

Equipment:

- ☐ Glasses
- ☐ AFOs if needed
- ☐ Splints
- ☐ Prone Stander
- ☐ Adaptive Chair
- ☐ Other:

Long Term Goals: *See attached IEP Annual Goals & Objectives*
Short Term Goals: *See attached IEP Annual Goals & Objectives*

Frequency: ___ per________

Duration: _______minutes

Therapist:____

Date:_________________________________