## **LOCKPORT AREASPECIAL EDUCATION COOPERATIVE**

## REQUEST FOR ASSISTIVE TECHNOLOGY STUDENT CONSULTATION

Student's Name:	Today's Date:
Resident District:	School Attending:
Current Grade:	Is Child in LASEC Program? If So, Please Specify:
Special Education Teacher:	General Education Teacher:
Name and Email of Team Member Requestion AT Consultation:	
List the names and titles of other individuals involved with the stu	dent (OT, SLP, etc.):
Student Characteristics:	
Works Independently Impulsive	Disorganized Poor Work Completion
UnintelligibleVerbal	Non-Verbal Easily Distracted
Gives Up Easily Active	Inattentive Other (Specify)
What <u>specific</u> area of need/concern for which your team is seeking assistive technology support? ( reading, writing, math, communication, organization, time management, imitating tasks/assignments, etc. ) Use additional paper is needed.	

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What specific interventions have already been tried to addre	ess the area of need?
What contact have you had with the parents regarding this cor	ncern? What additional information do you believe would be helpful?
Once completed inlease forward this document to v	our District Special Education Program Administrator for signature. If
·	ogram, forward to LASEC Administrator.
District Special Education Administrator Date	