Occupational Therapy
Fine Motor/Visual Motor Screening

I wish to have my child, ____,
Participate in the motor skill screening to be conducted by Destination Life. I have enclosed the fee of $40 (payable to Destination Life).

Child's Date of Birth:__________________ Age:_____________ Class:__________________

At what age and for what duration did your child crawl before walking?

At what age did your child walk unassisted?

Has your child experienced any surgeries or accidents requiring medical assistance (broken bones, ear tubes, concussions, etc)?

Does he or she have a diagnosis or disability? If so, what?

Has your child received occupational, physical or speech therapy services in the past?

Is your child currently receiving services?

Does your child demonstrate any difficulties in the classroom? If so, what are your concerns?

Please return the form to the administrative staff at the front desk.

_____________________________ _______________________________
Parent Name Parent Signature

_________________________________ _________________________
Email Address (Cell)

Destination Life
Destiantion KidzZone
Phone: (817) 473-1312 FAX: (866) 990-2813