

GPSB Assistive Technology Trial Use and Implementation Guide



AT to be tried: _____

Student's Name: _____ DOB: _____ Age: _____ Meeting Date: _____

School/Agency: _____ Grade/Placement: _____

Contact Person(s): _____

School/Agency Phone: _____ Address: _____

Persons Completing Guide: _____

Parent(s) Name: _____ Phone: _____

Parent(s) Address: _____

Goal for AT use: _____

ACQUISITION

Sources(s)	Person Responsible	Date(s) Available	Date Received	Date Returned

Person primarily responsible to learn to operate this AT: _____

Training

Person(s) to be trained	Training Required	Date Begun	Date Completed

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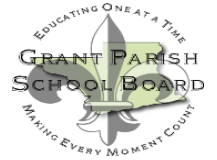
Management/Support

Location(s)	Support to be provided (e.g. set up, trouble shoot, recharge, program, etc;)	Person Responsible

Student Use

Date	Time Used	Location	Task(s)	Outcome(s)

GPSB Assistive Technology Trial Use and Implementation Summary



Student's Name: _____

Age: _____ Date Completed: _____

Person(s) Completing Summary: _____

Task Being Addressed During Trial: _____

Criteria for Success: _____

AT Tried	Dates Used	Criteria Met?	Comments (e.g. advantages, disadvantages, preferences, performance)

Recommendation for IEP: _____
