ORIENTATION AND MOBILITY CHECKLIST
AGES 3-22

Student:_____ Contact Person:_____ Phone#_____

The student: Has vision?__ Has light perception? ___ Has no vision?__
Travels independently?__ Without Aid?__ With Aid?__(i.e. walker, wheelchair)
Has had previous O&M training? ___yes ____no
Follows simple verbal commands? (stop, come here) ___yes ____no
Uses Low Vision Aids? (i.e. glasses, telescope, magnifier) ___yes ____no
Participates in extra curricular activities? (list)_____

School

Student:	Always	Sometimes	Never
Travels independently in class?	____	____	____
Maintains orientation traveling to:			
Classroom(s)	____	____	____
Restroom	____	____	____
Office	____	____	____
Cafeteria	____	____	____
Gym	____	____	____
Travels independently on campus?	____	____	____
Utilizes problem solving skills?	____	____	____
Negotiates familiar routes:			
Independently	____	____	____
W/Assistance	____	____	____

Problem Areas

___ Difficulty with stairs, steps, drop-offs
___ Bumps into other people or objects
___ Trouble adjusting to light changes
___ Difficulty in P.E.
___ Trouble w/ glare/shadow
___ Other?_____

Community (Discussed with appropriate person: parent, student, guardian, etc.)

Student:	Always	Sometimes	Never
Travels independently:			
In neighborhood	____	____	____
In community (malls, grocery store)	____	____	____
Utilizes public transportation?	____	____	____

Problem Areas

___ Difficulty with steps, drop-offs, curbs
___ Difficulty with uneven surfaces
___ Difficulty traveling at night
___ Other?_____
___Difficulty crossing streets
___ Sensitivity to sunlight
___Frequently gets lost

Comments/Concerns:_____

Please attach Doctor's eye report and Functional Vision report and Student Service Request form.