



Phone: 574-825-5666
 Fax: 574-825-8117
 Email: programs@lovewayinc.org

Legal Representative Assessment

Updated 4/28/2023

Participant Info

Participant Name: _____ Grade: _____

School: _____ Teacher: _____

Diagnosis/Disability: _____

Currently enrolled in: (Check all that apply)

Occupational Therapy Physical Therapy Other: _____

Participant Limitations

Speech/Hearing: _____

Vision: _____

Mobility: _____

Adaptive/Medical Equipment: _____

Other (Please Describe): _____

Participant Goals

Goal 1: _____

Goal 2: _____

Participant Behaviors

****Please provide/attach behavior intervention plan if applicable****

Behaviors: _____

Triggers: _____

Coping strategies or ways to redirect: _____

Legal Representative Signature: _____ Date: _____

Printed Name: _____ Relation to Participant: _____