

iLearn Evaluation Request

Child's Name: _____

Parent Name(s): _____ phone: _____

Email(s): _____ Best way to contact you: phone email

Current Therapies at LCA: _____

Current Therapies elsewhere: _____

Why are you interested in iLearn? _____

Which types of apps are you interested in looking at for your child:

_____ communication

_____ transitioning/schedules/sequencing activities

_____ positive behavior support

_____ early learning (cause & effect, alphabet, numbers)

_____ activities of daily living/social stories (visiting a doctor, shopping at the grocery store, eating at a restaurant)

_____ fun & games

_____ other: please describe _____

Do you own an iPad/iPhone/iPod touch device? Yes / No If yes, which device: _____

If yes, does your child currently use the device? If so please tell us a little more about how s/he uses it.

On a 1-5 scale, with 1 being least comfortable and 5 being most comfortable:

- | | | | | | |
|---|---|---|---|---|---|
| 1. Rate your comfort with Apple i-devices | 1 | 2 | 3 | 4 | 5 |
| 2. Rate your child's comfort with Apple i-devices | 1 | 2 | 3 | 4 | 5 |