

[office use only] Date Ordered _____ Initials _____ Details _____

Christina School District
Special Services

FAX To: Assistive Technology **302-454-5444** @ Tyre Avenue

REQUEST FOR PURCHASE of non-REACH ADAPTIVE EQUIPMENT

Date _____ **School:** _____ **Grade:** _____

Teacher: _____ *circle one:* REACH/Self-Contained/Inclusion/504

Person Requesting Equipment: _____ *circle all that apply:* Teacher/OT/PT/ST/ED/AT/ parent

Student _____ **Diagnosis/Academic Classification:** _____

Vendor _____ **Phone #** _____ **Fax #** _____

Address: _____ Website: www. _____

Item Number/Code	Quantity	Price (Each)	Total Price
1. _____			

Equipment Name: _____

2. _____			
----------	--	--	--

Equipment Name: _____

3. _____			
----------	--	--	--

Equipment Name: _____

Purpose of Equipment

- | | |
|--|--------------------------|
| <input type="checkbox"/> Safety | Rationale/Justification: |
| <input type="checkbox"/> Weight Bearing | _____ |
| <input type="checkbox"/> Independent Mobility | _____ |
| <input type="checkbox"/> Positioning for Classroom | _____ |
| <input type="checkbox"/> Sensory (hearing, vision, etc.) | _____ |
| <input type="checkbox"/> Augmentative Communication | _____ |

(Signature of Teacher/Therapist)

(Date)