



OCCUPATIONAL THERAPY ONSITE TEACHING CLINIC PEDIATRIC SELF-REFERRAL FORM 2026

The University of Puget Sound School of Occupational Therapy Teaching Clinic provides **FREE** services to community volunteers. Each session is led by a graduate level occupational therapy student, supervised by a licensed occupational therapist.

If you are interested in having your child participate in the UPS School of Occupational Therapy Teaching Clinic, please fill out the form below and **mail** or **fax** to the following: **1500 N. Warner Street #1070, Tacoma, WA 98416-1070. Fax#: 253-879-3518**

Upon receipt, a staff member will contact you to discuss participation and scheduling options. If you have any questions please call 253-879-3514 or email otclinic@pugetsound.edu.

CHILD INFORMATION		
Child's Name:		
Date of Birth:	Pronouns:	
Current Diagnosis (if applicable):		
Current Physician:		
Current Physician's Phone Number:		
Medications:		
Medical History:		
Are there any contraindications to participating in our onsite therapy teaching clinic?		
PARENT/GUARDIAN INFORMATION		
Name:		
Current address:		
City:	State:	ZIP Code:
Phone (Home / Cell):		
Alternate Phone (Home / Cell / Work):		
Relationship to child:	E-mail:	
EMERGENCY CONTACT		
Name:		
Address:		
City:	State:	ZIP Code:
Phone:	Email:	
Relationship to Child:		
REFERRAL INFORMATION		
Who referred your child to our teaching clinic?		
• Self • School • Therapist • Physician • Other:		
If you marked School, Therapist, or Physician above, please indicate the name and/or facility of the person who recommended our teaching clinic:		



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CHILD'S STRENGTHS

Please describe your child's strengths:

CHILD'S DEVELOPMENT

Please describe your child's development (include any difficulties in pregnancy, birth, or milestone development):

AREAS OF CONCERN (CIRCLE IF AN AREA OF CONCERN)

ACTIVITIES OF DAILY LIVING

- Feeding Self
- Eating
- Dressing
- Toileting
- Grooming & Hygiene
- Bathing

Please describe any concerns in this area:

Play/Social Skills

- Exploratory Play Skills
- Playing with Others
- Play Preferences
- Needs Adult Help to Play
- Ability to Make Friends
- Peer Interactions

Please describe any concerns in this area:

Fine and Gross Motor Skills

- Hand Skills
- Grasping/Pinching
- Use of Both Hands
- Coordination
- Balance
- Walking/Running

Please describe any concerns in this area:

Sensory Tolerance

- Likes/Dislikes Getting Dirty
- Likes/Dislikes Noise
- Likes/Dislikes Movement
- Likes/Dislikes Various Textures in Mouth

Please describe any concerns in this area:



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School Performance

• Name of Current School _____ Grade: _____

• Attention • Organization Skills • Writing • Keyboarding

Please describe any concerns in this area:

Mobility Devices

• Wheelchair • Assistive Devices

Please describe any mobility difficulties:

SPRING TEACHING CLINIC SCHEDULING

Please indicate your availability by marking 1 & 2 for your top two preferred times:

___ 8:00-8:45 am ___ 2:30 - 3:15 pm

___ 9:00 - 9:45 am ___ 3:30 - 4:15 pm

___ 10:00 - 10:45 am

Please indicate which day is preferred: ___TUESDAY ___THURSDAY

- ***Participants will be scheduled for either a Tuesday OR Thursday session time for the duration of clinic.***
- ***You will be contacted to discuss possible scheduling options only after all forms have been received and reviewed by the clinic coordinator.***

Forms can be returned to:

USPS mail:

UPS School of OT
Attn: Teaching Clinic
1500 N. Warner St. #1070
Tacoma, WA 98416-1070

FAX: (253) 879-3518

If you have any questions, please call the clinic office at (253) 879-3514.

Thank you!