

Switch Access Trials/Tally AT/AAC Data Collection

STUDENT: _____ **SWITCH STYLE:** _____ **RECORDER:** _____ **DATE:** _____ to _____

DIRECTIONS: Record switch access as instructed during Student's school day - minimal of two (2) times per day as permitted by student's state of being. If no trials can be completed, please note the date in the Date column and Check appropriate boxes, with comments as applicable. *All school calendar days must be recorded with Date and pertinent data, i.e., "ABSENT" checked in comment box if applicable.*

Each switch trial will be recorded in a separate section and/or as agreed. **SCORE KEY:** + (Switch activated), O (Switch not activated), NP (None present), NA (Not applicable), WNL (Within normal limits)

<u>Date</u>	<u>Location</u>	<u>Task</u>	<u>Position</u>	<u>Room Temp.</u>	<u>Noise Factors</u>	<u>Distracters</u>	<u>Process Time</u> (In seconds)	<u>Tally</u>
	<input type="checkbox"/> Classroom <input type="checkbox"/> Home <input type="checkbox"/> Other (Describe) _____	<input type="checkbox"/> Music/Tape <input type="checkbox"/> Computer <input type="checkbox"/> Vibrator <input type="checkbox"/> BigMack Recorded Message: _____ _____ _____	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Stander <input type="checkbox"/> Floor Mat <input type="checkbox"/> Tummy <input type="checkbox"/> Back <input type="checkbox"/> Side R L <input type="checkbox"/> Not able to complete				_____ _____ _____ _____	_____ _____ _____ _____
<u>Time</u>	<input type="checkbox"/> Not able to complete	<input type="checkbox"/> Not able to complete		<u>Lighting</u>	<u>Smell Factors</u>	<u>State of Being</u> <input type="checkbox"/> Smile/Grin <input type="checkbox"/> Irritable <input type="checkbox"/> Sleeping <input type="checkbox"/> Crying <input type="checkbox"/> Laughing (uncontrolled) <input type="checkbox"/> Left room <input type="checkbox"/> Other _____	<u>Cues/Prompts</u> <u>Comments:</u> <input type="checkbox"/> Not able to complete <input type="checkbox"/> Pain Medication <input type="checkbox"/> ABSENT	

<u>Date</u>	<u>Location</u>	<u>Task</u>	<u>Position</u>	<u>Room Temp.</u>	<u>Noise Factors</u>	<u>Distracters</u>	<u>Process Time</u> (In seconds)	<u>Tally</u>
	<input type="checkbox"/> Classroom <input type="checkbox"/> Home <input type="checkbox"/> Other (Describe) _____	<input type="checkbox"/> Music/Tape <input type="checkbox"/> Computer <input type="checkbox"/> Vibrator <input type="checkbox"/> BigMack Recorded Message: _____ _____ _____	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Stander <input type="checkbox"/> Floor Mat <input type="checkbox"/> Tummy <input type="checkbox"/> Back <input type="checkbox"/> Side R L <input type="checkbox"/> Not able to complete				_____ _____ _____ _____	_____ _____ _____ _____
<u>Time</u>	<input type="checkbox"/> Not able to complete	<input type="checkbox"/> Not able to complete		<u>Lighting</u>	<u>Smell Factors</u>	<u>State of Being</u> <input type="checkbox"/> Smile/Grin <input type="checkbox"/> Irritable <input type="checkbox"/> Sleeping <input type="checkbox"/> Crying <input type="checkbox"/> Laughing (uncontrolled) <input type="checkbox"/> Left room <input type="checkbox"/> Other _____	<u>Cues/Prompts</u> <u>Comments:</u> <input type="checkbox"/> Not able to complete <input type="checkbox"/> Pain Medication <input type="checkbox"/> ABSENT	