Student Name: _____ **Occupational Therapy Vest Data** Date Initiated:_____

Teacher:_____ To Be Returned to OT :_____

Classroom #: _____

This data is being collected as part of a 2-week trial to determine the effectivness of a weighted vest, weighted compression vest, or compression vest in the classroom. This vest should be worn for **no more than 30 minutes** at a time. If the student wants to take it off before than, that is acceptable. Once the student is done wearing the vest, he/she **cannot** wear the vest until after 30 minutes have passed. Please comment on the student's behavior after wearing the vest below.

Vest weight

Type of Vest: **WV** **WCV** **CV** Student weight:_____ Min: _____ Max:_____

(circle one)

Date	Time Vest put on	Durtion of vest on	Task/Activity	Behaviors/Effects				
				Calming	Moving/ Fidgeting	Attention to Task	Self-Removal	Activity Partici-pation

This trial was initiated upon caregiver agreement/consent. Please sign below, indicating that you understand the precautions and safety guidelines of using weighted and compression vests on children and the schedule at which it can be worn. Please contact your class occupational therapist with any questions or concerns regarding this trial.

Teacher Signature: _____