ROOM CONCEPT
Briefly describe your Sensory Room Concept

PURPOSE/OBJECTIVE FOR SENSORY ROOM (check all that apply):

- Active Play
- Calming
- Concentration
- Focus
- Relaxation
- Socialization
- Soft Play
- Stimulation
  - Visual
  - Auditory
  - Kinesthetic
  - Tactile

POPULATION SERVED
What are the developmental needs of the children and/or teens who will use the Sensory Room and/or Break Boxes! (check all that apply)

- ADHD
- Auditory Processing
- Autism
- Balance and Coordination
- Behavior Issues
- Cerebral Palsy
- Communication/Language
- Down Syndrome
- Sensory Integration
- Social Skills
- Other - please specify

What are the age ranges? __________________________

Do you need to accommodate wheelchair users? Yes ___ No ___

How many students do you expect will use the Sensory Room at the same time? 1-2 ___ 3-4 ___ more than 4 ___
FLOOR PLAN - Please attach room schematic if available

Length × Width of Room ___________________ Length × Width of Doorway ___________________

Ceiling Height ______________ Type of Ceiling ______________ Floor Covering ______________

Location of doors & windows ______________________________

BUDGET AND TIMING

Budget Range ______________________________

What’s your time frame for creating the Sensory Room? ______________________________

When do you need this quote? ______________________________

Anticipated Order Date ______________________________

Any specific products that are must-haves?

________________________________________________________________________________________

________________________________________________________________________________________

Any specific products that you do not want?

________________________________________________________________________________________

Any suggestions for new sensory products that we should develop? ______________________________

________________________________________________________________________________________

ADDITIONAL COMMENTS

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

CONTACT INFO

Your Name _______________________________________________________________________________

Your Role _______________________________________________________________________________

Name of your school or organization ______________________________ Tax Exempt? Yes ___ No ___

Address _________________________________________________________________________________

Phone ___________________________ Email ___________________________ Fax __________________________

Best time to reach you ___________________________

Please email the completed form to karen.obrien@enablingdevices.com or via fax 1-914-747-3480. We will respond within one or two business days.

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