ROOM CONCEPT
Briefly describe your Sensory Room Concept
_________________________________________________________________________________________
_________________________________________________________________________________________

PURPOSE/OBJECTIVE FOR SENSORY ROOM (check all that apply):
☐ Active Play ☐ Calming ☐ Relaxation ☐ Focus ☐ Soft Play
☐ Concentration ☐ Socialization ☐ Stimulation
☐ Visual ☐ Kinesthetic ☐ Auditory ☐ 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 ☐ Behavior Issues ☐ Cerebral Palsy ☐ Sensory Integration
☐ Autism ☐ Communication/Language ☐ Social Skills
☐ Balance and Coordination ☐ Down Syndrome ☐ 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 ___

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FLOOR PLAN - Please attach room schematic if available

Length x Width of Room ___________________ Length x Width of Doorway ___________________

Ceiling Height ___________ Type of Ceiling ___________ Floor Covering _______________

Location of doors & windows __________________ (include pictures of room when possible)

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 kareng@enablingdevices.com or via fax 1-914-747-3480. We will respond within one or two business days.