OMB No.:
Expiration Date:

MATHEMATICA
Policy Research, Inc.

Head Start Family and Child Experiences Survey

Teacher's Child Report Form – Head Start

Prepared by Mathematica Policy Research, Inc.

ID Number:_____

Child Name:_____

Section A.

A1. Are you currently the Head Start teacher for the child listed above? *(Use an "X" to mark your response.)*

1 ☐ Yes → **GO TO B1**

0 ☐ No

A2. What is the main reason you are no longer this child's teacher?

1 ☐ Child moved to another class in the same center

2 ☐ Child moved to another center

3 ☐ Child left the Head Start program

→ **GO TO A4**

A3. What is the name of the Head Start teacher whose class this child currently attends?

Name:_____

A4. Please record the last date this child was in your class.

|__|__| / |__|__| / |__|__|__|__|
Month Day Year

A5. Thank you for completing this form.

Section B. Child's Accomplishments

These questions are about things that different children do at different ages. These things may or may not be true for this child.

B1. Can this child recognize…

1 ☐ All of the letters of the alphabet,

2 ☐ Most of them,

3 ☐ Some of them, or

4 ☐ None of them?

B2. How high can this child count? Would you say…

1 ☐ Not at all,

2 ☐ Up to five,

3 ☐ Up to ten,

4 ☐ Up to twenty,

5 ☐ Up to fifty, or

6 ☐ Up to 100 or more?

B3. How often does this child like to write or pretend to write? Would you say…

1 ☐ Never,

2 ☐ Has done it once or twice,

3 ☐ Sometimes, or

4 ☐ Often?

B4. Can this child identify the colors red, yellow, blue, and green by name? Would you say…

1 ☐ All of them,

2 ☐ Some of them, or

3 ☐ None of them?

B4a. Can this child demonstrate a beginning understanding of the relationship between sounds and letters (e.g., the letter B makes a "buh" sound)? Would you say…

1 ☐ Not at all,

2 ☐ For one or two letters,

3 ☐ For a few (up to 5) letters, or

4 ☐ For several (6 or more) letters

B5. Please answer "Yes" or "No" to each question about this child's abilities.

	MARK "YES" OR "NO" ON EACH LINE	
	YES	**NO**
a. Does this child mostly write and draw rather than scribble?	1 ☐	0 ☐
b. Can this child write (his/her) first name even if some of the letters are backward?	1 ☐	0 ☐
c. Does this child trip, stumble, or fall easily?	1 ☐	0 ☐
d. When this child speaks, is (he/she) understandable to a stranger?	1 ☐	0 ☐
e. Does this child stutter or stammer?	1 ☐	0 ☐
f. Does this child ever look at a book with pictures and pretend to read?	1 ☐	0 ☐
g. Does this child recognize (his/her) own first name in writing or in print?	1 ☐	0 ☐
h. Does this child read any other words in writing or in print?	1 ☐	0 ☐
i. Can this child identify rhyming words?	1 ☐	0 ☐

MPR's agreement with the publisher/developer of this set of items does not allow us to share the items publicly without prior written approval.

Section D. Classroom Conduct

MPR's agreement with the publisher/developer of this set of items does not allow us to share the items publicly without prior written approval.

Section H. Approaches to Learning

MPR's agreement with the publisher/developer of this set of items does not allow us to share the items publicly without prior written approval.

Section F. Health and Developmental Conditions or Concerns

GO TO F5

F1. Has any professional such as a doctor or other health or education professional mentioned this child having a developmental problem or delay, for example, any special need or disability, such as physical, emotional, language, hearing difficulty or other special need?

MARK ONLY ONE

1 ☐ Yes

0 ☐ No → **GO TO F3**

d ☐ Don't know → **GO TO F3**

F2. How did the doctor or other health or education professional describe this child's needs or disability?

MARK ALL THAT APPLY

1☐ VISION IMPAIRMENT

2☐ BLINDNESS

3☐ HEARING IMPAIRMENT/HARD OF HEARING

4☐ DEAFNESS

5☐ MOTOR IMPAIRMENT

6☐ SPEECH IMPAIRMENT/DIFFICULTY COMMUNICATING

7☐ MENTAL RETARDATION

8☐ DEVELOPMENT DELAY

9☐ AUTISM OR PERVASIVE DEVELOPMENTAL DISORDER (PDD)

10☐ BEHAVIOR PROBLEMS/HYPERACTIVITY/ ATTENTION DEFICIT (ADD or ADHD)

11☐ OPPOSITIONAL DEFIANT DISORDER

12☐ OTHER *(Specify)*

_____

d ☐ Don't Know

F3. Since this child has enrolled in Head Start, has anyone reported concerns about (his/her) health or development?

Note: This item does not refer to normal health concerns (e.g., "she has a lot of colds"); it refers to the conditions listed in F4 below. The concerns may be identified by yourself, another staff member, a parent or anyone else.

1 ☐ Yes

0 ☐ No → **GO TO F6 ON NEXT PAGE**

d ☐ Don't know → **GO TO F6 ON NEXT PAGE**

F4. To your knowledge, what areas of this child's health and development appear to be of concern?

MARK ALL THAT APPLY

1☐ VISION IMPAIRMENT

2☐ BLINDNESS

3☐ HEARING IMPAIRMENT/HARD OF HEARING

4☐ DEAFNESS

5☐ MOTOR IMPAIRMENT

6☐ SPEECH IMPAIRMENT/DIFFICULTY COMMUNICATING

7☐ MENTAL RETARDATION

8☐ DEVELOPMENT DELAY

9☐ AUTISM OR PERVASIVE DEVELOPMENTAL DISORDER (PDD)

10☐ BEHAVIOR PROBLEMS/HYPERACTIVITY/ ATTENTION DEFICIT (ADD or ADHD)

11☐ OPPOSITIONAL DEFIANT DISORDER

12☐ OTHER *(Specify)*

_____

d ☐ Don't Know

F5. What has been done so far to address the child's condition or the concerns about the child's health and development?

The definition of IFSP/IEP is as follows: "a written plan that describes goals for this child and the services [he/she] should receive."

MARK ALL THAT APPLY

1 ☐ Discussions/plans are in progress

2 ☐ A specialist has been contacted

3 ☐ The child has been observed or evaluated

4 ☐ A meeting with the parents and the special needs team has been made

5 ☐ An individualized education plan (IEP) or an Individual Family Service Plan (IFSP) has been developed

6 ☐ Modifications or accommodations to the classroom or class activities have been made

d ☐ Don't Know

IF F5 = 5 (An IEP or IFSP has been developed)**, GO TO F5A. OTHERWISE, GO TO F6.**

F5a. Did you participate in the child's IEP or IFSP meeting?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

F5b. Which of the following services has the child received?

MARK ALL THAT APPLY

1 ☐ Speech or language therapy

2 ☐ Social work services

3 ☐ Psychological services

4 ☐ Special education teacher services

5 ☐ Other services

d ☐ Don't Know

IF F5B = 1, 2, 3, 4, OR 5, GO TO F5C. OTHERWISE, GO TO F6.

F5c. How were these services delivered?

MARK ALL THAT APPLY

1 ☐ Consultation in the classroom

Note: Consultation includes recommending modifications, accommodations, or other methods to support the child's learning and development

2 ☐ Direct teaching or services by a specialist in the classroom

3 ☐ Direct teaching or services by a specialist in another classroom or setting

d ☐ Don't Know

F6 IS NOT ASKED IN FALL 2009

F6. About how often has this child missed a Head Start class during the past year?

1 ☐ Never

2 ☐ 1-5 days

3 ☐ 6-10 days

4 ☐ 11-20 days

5 ☐ More than 20 days

G1. Why did you choose to complete the paper questionnaire rather than complete the questionnaire on the Web?

MARK ALL THAT APPLY

1 ☐ Did not have access to a computer

2 ☐ Computers were in use by others at the times I wanted to do the questionnaire

3 Started survey, but experienced technical problems such as…

- 3a ☐ Screen frozen
- 3b ☐ took too long to load the first page
- 3c ☐ Took too long to load subsequent pages

4 Tried to log into Web address, but an **error message** appeared…

- 4a ☐ "Invalid password"
- 4b ☐ "This page has expired"
- 4c ☐ "This website is busy, please try again later"

5 ☐ Computer screen too small to read questions, such as required too much scrolling—up or down, side to side

6 ☐ Unable to read the questions on the screen because of the color scheme on the computer

7 ☐ Chose to complete the paper questionnaire because it was readily available

G2. What kind of help could we have given you to make it easier to complete this form on the web?

_____

_____

_____

_____

_____

Thank you for your participation in FACES!