

ATTACHMENT A.2
CLASSROOM SELECTION FORM

OMB No: 0970-0355

Expiration Date: 1/31/15 **Head Start Family and Child Experiences Survey Pilot Study**

Classroom Selection Form

Program

:

Address:

Phone

:

City:

State

Fax:

:

Selected Center 1: [INSERT CENTER 1 NAME]

Center Director: _____

Address 1: _____

Address 2: _____

Phone: _____

Fax: _____

Email Address: _____

Selected Center 2: [INSERT CENTER 2 NAME]

Center Director: _____

Address 1: _____

Address 2: _____

Phone: _____

Fax: _____

Email Address: _____

Now that centers in your program have been selected for participation in the FACES Pilot Study, we need some information about the classrooms in each of the selected centers. We will use this information to select two classrooms in each center for participation.

1. Please confirm all contact information pre-filled above for your program and the selected centers.
2. On page 2, list each classroom currently in operation at each selected center.
3. Return the completed form to your Mathematica Coordinator no later than **[DATE]**.

Mathematica Coordinator:

Name: _____

Address 1: _____

Address 2: _____

Phone: _____

Fax: _____

On-Site Coordinator:

Name: _____

Address 1: _____

Address 2: _____

Phone: _____

Fax: _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 0970-0355. The time required to complete this collection of information is estimated to average 20 minutes, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the collection of information. This information collection is voluntary. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Mathematica Policy Research, 1100 1st Street, NE, 12th Floor, Washington, DC 20002, Attention: Jerry West.

Email Address: _____

Email Address: _____

BOX A. CLASSROOMS AT [INSERT CENTER NAME]

| Teacher Name | AM, PM or Full- Day | Number of Children | | | Percentage of Dual Language Learner Children | Days Classroom Operates |
|--------------|---------------------------|--------------------|-----------------|-----------------|--|----------------------------|
| | | 3-Year- Olds | 4-Year- Olds | 5-Year- Olds | | |
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BOX B. CLASSROOMS AT [INSERT CENTER NAME]

| Teacher Name | AM, PM or Full- Day | Number of Children | | | Percentage of Dual Language Learner Children | Days Classroom Operates |
|--------------|---------------------------|--------------------|-----------------|-----------------|--|----------------------------|
| | | 3-Year- Olds | 4-Year- Olds | 5-Year- Olds | | |
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