

DRAFT

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**American Indian and
Alaska Native Head Start
Family and Child
Experiences Survey**

Teacher's Child Report Form



**American Indian and
Alaska Native**

family and child experiences survey

Paperwork Reduction Act Statement: The referenced collection of information is voluntary. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The valid OMB control number for this information collection is 0970-0151 which expires XX/XX/2018. The time required to complete this collection of information is estimated to average 10 minutes, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the collection of information. 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.

Survey Information

Mathematica Policy Research is conducting the American Indian and Alaska Native Head Start Family and Child Experiences Survey (FACES) under contract with the Administration for Children and Families (ACF) of the U. S. Department of Health and Human Services (DHHS).

To enhance the information we obtain by assessing the children and surveying their parents, we need for you to complete this brief questionnaire, The Teacher Child Report, about each of the children in the study who are from your class. The Teacher Child Report (TCR) asks you to report on the social skills, problem behaviors, and approaches to learning that you have observed in these children from your class.

Please be assured that all information you provide will be kept private to the extent permitted by law. Your participation in the study is voluntary and you may refuse to answer any questions you are not comfortable answering. Your answers will be completely private and will not be shared with parents or other staff in your center, or anybody else not working on this study. The survey will take about 10 minutes for each child.

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I agree that I understand the purpose of this study including privacy assurances, and that my participation is completely voluntary. I may withdraw this consent at any time without penalty.

Signature _____ Today's date _____
Name (print) _____

ID Number: _____

Child Name: _____

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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 <input type="checkbox"/>	0 <input type="checkbox"/>
b. Can this child write (his/her) first name even if some of the letters are backward?.....	1 <input type="checkbox"/>	0 <input type="checkbox"/>
c. Does this child trip, stumble, or fall easily?.....	1 <input type="checkbox"/>	0 <input type="checkbox"/>
d. When this child speaks, is (he/she) understandable to a stranger?.....	1 <input type="checkbox"/>	0 <input type="checkbox"/>
e. Does this child stutter or stammer?.....	1 <input type="checkbox"/>	0 <input type="checkbox"/>
f. Does this child ever look at a book with pictures and pretend to read?.....	1 <input type="checkbox"/>	0 <input type="checkbox"/>
g. Does this child recognize (his/her) own first name in writing or in print?.....	1 <input type="checkbox"/>	0 <input type="checkbox"/>
h. Does this child read any other words in writing or in print?.....	1 <input type="checkbox"/>	0 <input type="checkbox"/>
i. Can this child identify rhyming words?.....	1 <input type="checkbox"/>	0 <input type="checkbox"/>

Section C. Social Skills

Mathematica'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

Please describe this child according to how true each of these statements has been during the past month, from “not true” to “somewhat or sometimes true” to “very true or often true.” For each item, mark only one code.

	MARK ONLY ONE		
	NOT TRUE	SOMEWHAT OR SOMETIMES TRUE	VERY TRUE OR OFTEN TRUE
a. Acts too young for his or her age.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Can't concentrate, can't pay attention for long.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. <i>Mathematica's agreement with the publisher/developer of this item does not allow us to share the items publicly without prior written approval.</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. <i>Mathematica's agreement with the publisher/developer of this item does not allow us to share the items publicly without prior written approval.</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e. Hard to understand what he or she is saying.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f. Hits or fights with others.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
g. Keeps to herself or himself; tends to withdraw.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
h. Lacks confidence in learning new things or trying new activities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
i. Is nervous, high-strung, or tense.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
j. Is very restless, fidgets all the time, can't sit still.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
k. Often seems sleepy or tired in class.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
l. Has temper tantrums or hot temper.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
m. Often seems unhappy, sad, or depressed.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
n. Worries about things for a long time.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

Section H. Approaches to Learning

H1. Please describe this child according to how he or she approaches tasks. How often in the past month did he or she act this way? For each item, mark only one code: “never,” “sometimes,” “often,” or “very often?”

	MARK ONLY ONE FOR EACH ITEM			
	NEVER	SOMETIMES	OFTEN	VERY OFTEN
a. Keeps belongings organized.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. Pays attention well.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c. Shows eagerness to learn new things.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d. Easily adapts to changes in routine.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e. Persists in completing tasks.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f. Works independently.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

Section F. Health and Developmental Conditions or Concerns

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

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

GO TO F5

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

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?

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

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

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 2015

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

Section G.

Thank you for your participation in FACES!

G1 AND G2 ASKED ONLY IF COMPLETING HARD COPY

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?
