OMB No.: 0970-0151

Expiration Date: XX/XX/XXXX

**FACES 2019**

**Experiences in Head Start**

**Experiences in Head Start**

**Head Start Family and Child Experiences Survey 2019**

**(FACES 2019)**

***Teacher Child Report Form***

***Fall 2019 - Spring 2020***

**AFFIX LABEL HERE**

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**Survey Information**

Mathematica Policy Research is conducting the Head Start Family and Child Experiences Survey 2019 (FACES 2019) 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 form, 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 form will take about 10 minutes for each child.

Section A.

Section B. Child’s Accomplishments

**A1. Are you currently the Head Start teacher for the child listed on the front of this survey? *(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 **GO TO A3**

 2 🞎 Child moved to another center **GO TO A3a**

 3 🞎 Child left the Head Start program **GO TO A4**

 4 🞎 Child was never in my class/

 I don’t know this child **GO TO A5**

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

 Name:

**A3a. What is the name of the Head Start center where this child went?**

 Name:

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

 | | | / | | | / | | | | |

 Month Day Year

**A5. Thank you for completing this form.**

**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?

 4 🞎 CHILD IS COLOR BLIND

Section C. Social Skills

**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 🞎 |

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

Section H. Approaches to Learning

Section E. Preschool Learning Behavior Scale

**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 ONE PER ROW  |
|  | **NEVER** | **SOMETIMES** | **OFTEN** | **VERY OFTEN** |
| a. Keeps belongings organized  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 |
| b. Pays attention well  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 |
| c. Shows eagerness to learn new things  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 |
| d. Easily adapts to changes in routine  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 |
| e. Persists in completing tasks  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 |
| f. Works independently  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 |

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

## GO TO F3

 d 🞎 Don’t know

**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

## GO TO G1

 d 🞎 Don’t know

**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 G1.** |

**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 G1** |

**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

|  |
| --- |
| **SPRING ONLY** |

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

 1 🞎 Never,

 2 🞎 One to five days,

 3 🞎 Six to ten days,

 4 🞎 Eleven to twenty days, or

 5 🞎 More than twenty days?

Section G.

Section G.

**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 2019!**