

CONFIDENTIAL

Check potential concerns with child (ages 5-12), indicating how long you've observed them (1, 2 or 3+ months).

Child's Name:

Date:

Behavioral Changes

	1 mo	2 mo	3+ mo
<input type="checkbox"/> Blames other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Refuses to share	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Steals from other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cruel to other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Refusal behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Behavior changes are: new increasing

Illness and Injury

	1 mo	2 mo	3+ mo
<input type="checkbox"/> Complains of aches and pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gets hurt frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Takes unnecessary risks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Illnesses, injuries or risk-taking are:

new increasing



Emotional Signs

	1 mo	2 mo	3+ mo
<input type="checkbox"/> Flat facial affect and/or does not show emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Does not seem to understand feelings of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spends more time alone than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Has disengaged from friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fidgety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Easily distracted and/or has difficulty staying on task	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Overly angry, hyper sensitivity, frequent crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

These signs are:

new increasing



Hygiene Changes

	1 mo	2 mo	3+ mo
<input type="checkbox"/> Body odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dirty hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dirty clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hygiene changes are: new increasing

Classroom Productivity

	1 mo	2 mo	3+ mo
<input type="checkbox"/> Misses school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Misses class assignments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Afraid to leave school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Class changes are: new increasing

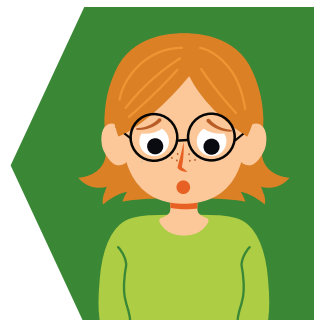


Communication Frequency

	1 mo	2 mo	3+ mo
<input type="checkbox"/> Vocal child suddenly becomes quiet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Quiet child suddenly becomes inappropriately loud	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Uses inappropriate language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Communication changes are:

new increasing



If you've checked 2 or more items, please proceed to page 2

Additional Description

Do you have important detail or context to add to your observations?

Sharing Your Concerns

I will bring my concerns to the attention of (Write their name):

Date Contacted

- | | |
|---|-------|
| <input type="checkbox"/> School Nurse: _____ | _____ |
| <input type="checkbox"/> School Counselor: _____ | _____ |
| <input type="checkbox"/> Principal: _____ | _____ |
| <input type="checkbox"/> Student Support Team Lead: _____ | _____ |
| <input type="checkbox"/> Head Teacher: _____ | _____ |

Contacting Parents

I have contacted the child's parent(s) (Write parent name by method used):

Date Contacted

- | | |
|---|-------|
| <input type="checkbox"/> Phone conversation with: _____ | _____ |
| <input type="checkbox"/> Text message to: _____ | _____ |
| <input type="checkbox"/> In-person meeting with: _____ | _____ |
| <input type="checkbox"/> Written letter to: _____ | _____ |
| <input type="checkbox"/> Email (if organization allows) to: _____ | _____ |

About the Observer

Your Name:

Your Role:

(i.e., are you a Teacher, School Nurse, Camp Counselor, etc.?):