Akron Children's Hospital

Dear Teacher(s),

Your input is being requested because one of your students is participating in a developmental assessment conducted through the NeuroDevelopmental Science Center at Akron Children's Hospital. Please complete both sides of the attached Teacher Questionnaire and return them to our office via mail or fax. The information in these forms will be used as part of the child's assessment and will provide valuable insight into the child's strengths, difficulties, and overall functioning at school. Thank you for your time.

Please return to:

NeuroDevelopmental Science Center, William H. Considine Building

215 W. Bowery St., Akron, OH 44308

Phone: 330-543-8050

Fax: 330-543-6045

Akron Children's Hospital

ADC Teacher Questionnaire

NOTE TO PARENT/GUARDIAN: Please sign the following release and give this form to your child's teacher to fill out and return it to us.

PARENTAL CONSENT: I give consent for my child's teacher to complete the following background form.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

_____ _____
CHILD'S LAST NAME, FIRST NAME DATE OF BIRTH

Dear Teacher:

(child's name)_____, is scheduled for an evaluation of his/her development and behavior. Since much of the child's day is spent with you, a description of behavior and your impressions of this student would be extremely helpful.

Teacher Name: _____ Date Form Completed: _____

1. What grade level and type of class do you teach? _____

2. How long have you known this student/child? _____

3. Does this child receive services and/or accommodations through an IEP or a 504 Plan? If so, please describe:
_____
_____

4. What are the child's strengths? _____
_____
_____

5. What does the child have more difficulty with? _____
_____
_____

6. In the box provided, please rate the child's developmental progress in the following domains on a scale of 1-5 (1 being no concept yet and 5 being well above average relative to neurotypical peers) and briefly describe the child's skill level:

1 - 5

☐ a. **Concepts** (colors, shapes, size concepts, etc.): _____
_____

☐ b. **Preliteracy** (I.D. letters, label letters, ABC's, sight words, etc.): _____
_____

☐ c. **Prenumeracy** (rote counting, counting objects, I.D. numbers, label numbers, etc.): _____
_____

☐ d. **Prewriting** (I.D. name in print, write letters in name, write name, etc.): _____
_____

7. If applicable, what supports or strategies/interventions have been implemented to address academic concerns (please include if they have been effective/successful)? _____
_____

8. How does the child interact with his peers? _____
_____

9. Does this child demonstrate any challenging behavior(s)? If so, please describe: _____
_____

a. What strategies/supports have been implemented and have been successful to address this behavior? _____

_____

b. What strategies/supports have not been successful? _____

_____

Below you will find a list of possible areas of development or behavior that may be of concern to you.

Please check one box to the right of each of item. **My student:**	**Never**	**Some -times**	**Often**	**Very Often**
1. Has trouble looking people in the eyes/making eye contact				
2. Does not point or use gestures to communicate needs (like which snack) or interests (like pointing out a toy on a shelf)				
3. Is not showing interest in interacting or making friends with other children				
4. Does not seek praise for accomplishments or to be proud				
5. Has trouble understanding other peoples' feelings or emotions				
6. Has trouble taking turns				
7. Is delayed with or does not talk and/or does not understand when other people talk				
8. Repeats back what has just been said instead of answering				
9. Recites language memorized from TV or movies				
10. Lacks pretend or creative play				
11. Does not play with toys the way they were made or stacks/lines up objects repetitively instead of playing with them				
12. Has trouble playing with other children his/her age				
13. Has an intense or overly-focused interest in certain topics or toys/objects				
14. Has significant need for specific routines or rituals that often have no real purpose				
15. Engages in repetitive movements like finger flicking, hand flapping, rocking, spinning, pacing, head banging or toe walking				
16. Has a preoccupation with parts of objects like spinning wheels or opening and closing doors				
17. Lack variation in pitch or tone of his/her voice (such as a mechanical quality), nasal sound, or an overly exaggerated inflection				
18. Use unusual voice volume (too loud/too soft) for the setting s/he is in				
19. Has sensory sensitivity to noises, smells, touch/texture (please circle)				
20. Has sensory seeking behavior such as wanting to touch, smell, or mouth objects				
21. Has difficulty with transitioning from one activity to another				
22. Has difficulty with change in routine				
23. Does not respond to his/her name				
24. Has a flat expression or does not use facial expressions to let you know how s/he is feeling				
25. (for older children) has difficulty understanding humor or sarcasm, is very literal				
26. (for older children) has difficulty taking turns during a conversation				

Please provide any other thoughts or concerns that you feel would be helpful for us to know about:

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire. Please return to:
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