



CLASS Academy

Student Assistance Program

Parent Questionnaire

Your son or daughter has been referred to the Student Assistance Team. The Student Assistance Program (SAP) is designed to assist parents in helping their child affectively deal with issues that may be barriers to their success and learning. The information gained through this process will be used to help determine the best way we can help your child.

This form is a questionnaire used to identify your child's strengths and challenges. Please complete the following information as soon as possible and return to school.

Student Name:		Date:	
Parent / Guardian Name:			
Relationship to Student:			

STRENGTHS:

Please check all that you believe best describe your son or daughter

<input type="checkbox"/>	Able to work independently
<input type="checkbox"/>	Joins in extra curricular activities at school or in community
<input type="checkbox"/>	Works well in groups
<input type="checkbox"/>	Wants to and likes to learn
<input type="checkbox"/>	Displays good logic/reasoning and decision making
<input type="checkbox"/>	Is a good leader
<input type="checkbox"/>	Can accept criticism
<input type="checkbox"/>	Considerate of others
<input type="checkbox"/>	Good communication skills
<input type="checkbox"/>	Cooperative
<input type="checkbox"/>	Possesses good interpersonal skills
<input type="checkbox"/>	Displays positive values(honesty respect,caring,etc.)
<input type="checkbox"/>	Follows Rules
<input type="checkbox"/>	Uses time wisely
<input type="checkbox"/>	Helps others
<input type="checkbox"/>	Is connected to and likes school and staff
<input type="checkbox"/>	Strives to Achieve their best
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Other: _____

PERSONALITY:

Please check all that you believe best describe your son or daughter

<input type="checkbox"/>	Noticeable mood swings
<input type="checkbox"/>	Frequent, extreme highs and lows
<input type="checkbox"/>	Crying seemingly without explanation
<input type="checkbox"/>	Appearing very irritable or hostile without reason
<input type="checkbox"/>	Extremely negative or apathetic attitude
<input type="checkbox"/>	Spending a lot more time alone than normal
<input type="checkbox"/>	Exhibiting general loss of energy, motivation, interest or enthusiasm
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Other: _____

FRIENDS / RELATIONSHIPS:

Please check all that you have observed with regard to your child's friends/relationships

<input type="checkbox"/>	Stopped spending time with old friends
<input type="checkbox"/>	Hanging out with friends you don't know
<input type="checkbox"/>	Doesn't want you to meet his or her friends
<input type="checkbox"/>	Friends immediately go into child's room to avoid contact with family members
<input type="checkbox"/>	Not communicating plans or where they are going
<input type="checkbox"/>	Spends less time in family activities
<input type="checkbox"/>	Is verbally or physically abusive towards family members
<input type="checkbox"/>	Blaming others / Refusing to take responsibility for self
<input type="checkbox"/>	Refused to follow family rules.
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Other: _____

STRENGTHS:

Please check all that best describe your child's behavior at home.

<input type="checkbox"/>	Does household chores
<input type="checkbox"/>	Generally complies with family rules
<input type="checkbox"/>	Participates in family activities, meals, etc.
<input type="checkbox"/>	Cares about appearance, health, etc.
<input type="checkbox"/>	Takes appropriate pride in self and property
<input type="checkbox"/>	Behavior is appropriate with other children (peers, siblings, etc.)
<input type="checkbox"/>	Generally respectful towards adults
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Other: _____

Please complete back of form

SCHOOL:					PHYSICAL TRAITS:				
<i>Please check all that you have observed with regard to your child's school experiences.</i>					<i>Please check all that apply in regard to your child's physical health and appearance.</i>				
<input type="radio"/>	Experiencing more problems in school than usual				<input type="radio"/>	Unsteady on feet			
<input type="radio"/>	Recent or rapid drop in academic performance				<input type="radio"/>	Noticeable change in height			
<input type="radio"/>	Lack of participation in extracurricular activities such as sports, clubs, etc.				<input type="radio"/>	Complaining of nausea/stomach aches			
<input type="radio"/>	Forged your signature				<input type="radio"/>	Glassy / bloodshot eyes			
<input type="radio"/>	Having problems getting your child to go to school				<input type="radio"/>	Unexplained physical injuries			
<input type="radio"/>	Other: _____				<input type="radio"/>	Poor motor skills			
<input type="radio"/>	Other: _____				<input type="radio"/>	Frequent cold-like symptoms			
CRISIS INDICATORS:					<input type="radio"/>	Loss of hair			
<i>Please check all that you have observed with regard to your child</i>					<input type="radio"/>	Self abuse / mutilation			
<input type="radio"/>	Has expressed a desire to die				<input type="radio"/>	Poor hygiene			
<input type="radio"/>	Given away personal possessions				<input type="radio"/>	Preoccupied with personal health issues			
<input type="radio"/>	Has expressed desire to join someone who has died				<input type="radio"/>	Fatigue / constantly tired			
<input type="radio"/>	Has made suicidal threats / gestures				<input type="radio"/>	Disoriented			
<input type="radio"/>	Has experienced a recent death of family member or close friend				<input type="radio"/>	Change in sleep habits			
<input type="radio"/>	Other stressors (Please explain)				<input type="radio"/>	Headaches			
					<input type="radio"/>	Refusal to eat			
					<input type="radio"/>	Other: _____			
					<input type="radio"/>	Other: _____			
					LEGAL:				
					<i>Please check all that you have observed with regard to your child</i>				
					<input type="radio"/>	Been caught taking items from home or neighbors home			
					<input type="radio"/>	Family members missing money or items from the home			
					<input type="radio"/>	Recently sold personal possessions.			
					<input type="radio"/>	Other: _____			
					<input type="radio"/>	Other: _____			
What are your concerns for your child that may be a barrier to his or her learning?									

What does your child tell you about his or her school experience?									

Would you like to speak directly with a member of the SAP team?									
<input type="radio"/>	Yes								
<input type="radio"/>	No								