

School Follow-up Questionnaire

Student's Name _____ Date _____
School _____ Grade _____ Phone _____
Form completed by/Title _____ How may we contact you _____
Subject/Title _____
Period/time of day _____ Current class grade/score _____

I. Current Program: Check all of the services this child is receiving below.

- | | |
|--|--|
| <p><input type="checkbox"/> A. Regular classroom(s): approximate number of students _____</p> <p><input type="checkbox"/> B. Special accommodations in classroom or 504 Plan please describe: _____
_____</p> <p><input type="checkbox"/> C. Chapter Reading, Chapter Math, Reading Recovery, Gifted&Talented (please circle any that apply) IEP</p> <p><input type="checkbox"/> D. Special Education: Hours per week _____
Areas: <input type="checkbox"/> Reading <input type="checkbox"/> Writing <input type="checkbox"/> Spelling
<input type="checkbox"/> Math</p> | <p><input type="checkbox"/> E. Skill Building: <input type="checkbox"/> Study Skills <input type="checkbox"/> Social Skills Groups <input type="checkbox"/> Anger Management Groups</p> <p><input type="checkbox"/> F. Other Services: <input type="checkbox"/> Speech/Language Therapy
<input type="checkbox"/> Occupational Therapy</p> <p><input type="checkbox"/> G. Counseling (specify sessions/week):
Counselor _____ Social Worker _____
Mentor _____ Classroom Aide _____
PSR _____ IBI _____</p> |
|--|--|

II. Please describe this student's areas of STRENGTH _____

Please describe this student's areas of WEAKNESS (or areas where not where not working to potential)

III. Please answer the following regarding this student's medication (if on medicine):

Does it seem to wear off before the next dose? Yes No

Does the student take it as scheduled at school? Yes No

Are there undesirable effects of medication? Yes No

If yes, what are they? _____

IV. Please describe what differences (positive or negative) there are between this student's *medicated* and *unmedicated* states. _____

V. Please indicate any questions or concerns you have, as well as your thoughts about this student's rate of progress and general school performance and adjustment (is student performance up to his/her ability). Yes No _____

VI. Do you have any suggestions regarding this follow-up visit? Yes No

If yes, please specify: _____

NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child was on medication was not on medication not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

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NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance	Somewhat of a Problem				
	Excellent	Above Average	Average	Problem	Problematic
Academic Performance					
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Somewhat of a Problem				
	Excellent	Above Average	Average	Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Side Effects: Has the child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

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