



Dear Teacher, Please complete and return this form as soon as possible to:
 Dr. Perrin Dr. Bresnahan Dr. Miller Dr. Steiner

_____ (Parent Signature)

Center for Children with Special Needs

Floating Hospital for Children
NEMC #334, 750 Washington St.
Boston, Massachusetts, 02111

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Phone (617) 636-7242

Observer's Report Form (Under Five) revised 11-04

This form can be used by family members, teachers, classroom aides, therapists, child care providers or other observers as needed. Your observations are useful in understanding this child's current functioning in a variety of settings.

Child's Name: _____ Age: _____ Date: _____

Person(s) completing form: _____ Relationship: _____

Setting: _____ Time of day observed: _____

NOTE: Please attach reports, evaluations or current Individual Family Service Plans (IFSP) if any.

➤ Is this child receiving Special education services, Head Start, Early Intervention or private services? **No Yes**
If yes, please describe services:

➤ Please describe your main CONCERNS at this time: (developmental skills, behavior, attention span, work habits, social skills, emotional responses, motor skills, academic readiness skills, etc.):

➤ Please comment on this child's significant STRENGTHS:

■ Continues
on other side

➤ Please complete this survey comparing this child to children of the same age and sex.

Current Performance Survey	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
Overall developmental level?				
Language skills?				
Fine Motor skills?				
Gross Motor skills?				
Self-help skills?				
Pre-academic skills?				
Overall behavior?				
Attention span or distractibility?				
Activity level?				
Impulse control?				
Unusual behaviors?				
Aggression?				
Cooperation?				
Emotional functioning?				
Relationship with adults?				
Relationship with parents?				
Relationships with other children?				

Please comment on your responses in the space below.

➤ Does this child have any health problems or take any medications for chronic or acute health problems?

- Don't know No Yes If yes please specify:

➤ Does this child take medications for emotional or behavioral problems, such as Attention-Deficit/Hyperactivity Disorder?

- Don't know Never Medication in past (please specify) Current medication (please specify)

➤ Is there any other information about the child, the family, school setting or the situation that would be helpful?

➤ What do you think might help this child function better?

Thank you very much.