Child's Name: _____

Date of Birth: _____

Head Start Center: _____

Mental Health Checklist

When student is suspected of having a mental health concern, please complete and submit the following to Lupita Castaneda (Mental Health Coordinator):

_____ Mental Health Referral from Head Start
_____ Mental Health Screener
_____ Observation Notes
_____ Mental Health Parent Questionnaire
_____ Medical Diagnoses (Outer Agency Evaluations and/ or other supporting documentation: Physical exam/Developmental Eva. Neurological Eva. Etc.)
_____ Results of Lap B-K

Date Received by Mental Health Coord: _____

N.I.N.O.S., Inc. Head Start/ Early Head Start Program
Mental Health Referral

Child's Personal Information

Name: _____ Date of Birth: _____

Parent's Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone:_____

Enrollment Information

Center: _____ Teacher_____

Date of Child Enrollment: _____ Language Child Speaks: _____

Abnormalities on Physical: _____ Other Documentation: _____

Vision _____ Hearing_____

Lab-D
Screening_____ Pass/ Fail

Lap-D/E-Lap
Assessment: _____Above Average/Average/Below Average

Referral Information

Reason for referral: _____

_____

Has parent been informed: Yes/ No Parent Comments: _____

Is child receiving services anywhere? : Yes/ No Agency/ Doctors_____

Refusal of Services

Reason for refusal: _____

_____

Supporting Documentation (Please include all supporting documentation with referrals)

___ Observations ____Assessments_____ Progress notes _____ Lab-3 results (Low / High)

Medical Records/reports _____

Others Documentation:_____

_____ _____ _____ _____
Parent Signature Date Center Staff Signature Date

_____ _____
Mental Health Coordinator Signature Date

NINOS, Inc. Head Start/Early Head Start

Mental Health Screener
(Teacher Must Complete)

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

Classroom: _____

Date of Concern: _____

Child's Strengths (Check all that apply):

- ☐ Friendly
- ☐ Honest
- ☐ Creative
- ☐ Leadership
- ☐ Helpful
- ☐ Seeks Relationships
- ☐ Curious
- ☐ Kind
- ☐ Self-Control
- ☐ Completes Tasks
- ☐ Engages with Peers
- ☐ Interest in a Hobby
- ☐ Cooperative
- ☐ Loving
- ☐ Playful
- ☐ Maintains Attention
- ☐ Asks for Help
- ☐ Other (specify):

Areas of Concern (Check all that apply):

- ☐ Easily Distracted
- ☐ Aggressive
- ☐ Excessive Energy
- ☐ Separation Anxiety
- ☐ Difficulty with Peers
- ☐ Throws/Damages Property
- ☐ Nervous/Anxious/Fearful
- ☐ Cries Easily for Age
- ☐ Lying
- ☐ Family Concerns (specify)
- ☐ Passive/Withdrawn
- ☐ Difficulty with Transitions
- ☐ Defiance/Disrespectful
- ☐ Inattentive
- ☐ Grief/Loss
- ☐ Profanity
- ☐ Self-Injurious
- ☐ Dramatic Change in Behavior
- ☐ Running Away
- ☐ Frequent Absences
- ☐ Perfectionist
- ☐ Hygiene
- ☐ Fighting/Bullying
- ☐ Sadness
- ☐ Self-Image
- ☐ Acting out Sexually
- ☐ Trauma/Neglect (specify)

Use this area to further describe your concerns:

Frequency: (when is behavior displayed)

- ☐ Weekly
- ☐ Every Couple Days
- ☐ Daily
- ☐ Multiple Times per Day
- ☐ Other (specify):

Activities where behavior occurs (check all that apply):

- ☐ Arrival
- ☐ Circle Time
- ☐ Meal Time
- ☐ Centers
- ☐ Playground/Gym
- ☐ Special Events (ex. Library)
- ☐ Transitions
- ☐ Departure
- ☐ Other (specify):

What do you perceive as the primary function and/or reason behind the child's behavior:

- ☐ Seeking Connection
- ☐ Inability to Regulate
- ☐ Over/Under Stimulated
- ☐ Anxious Response
- ☐ Avoidance
- ☐ Needs Skill Building
- ☐ Triggered/Trauma Response
- ☐ External Factors/Changes
- ☐ Other (specify):

Use this space to explain rationale and/or provide anecdotal support:

Please describe the strategies used to teach an alternative behavior and/or changes made to accommodate the child's needs:

Teacher Signature: _____ Date: _____

Area Manager Signature: _____ Date: _____

Mental Health Coordinator Signature: _____ Date: _____

Mental Health Professional/Consultant Signature: _____ Date: _____

OBSERVATION NOTES

Child's Name: _____

DOB: _____

Date of observation: _____

Center Name: _____

Teacher's Name: _____

Time: _____

Time: _____

Time: _____

White Copy-Mental Health Coordinator Yellow Copy- Child's Folder