Classroom Questionnaire
Standardization Phase

Harcourt Assessment, Inc. invites you to participate in the Standardization of the Classroom Questionnaire. This checklist is a behavior scale that enables teachers to report sensory information that is vital to:

- understanding the complexity of a student’s sensory processing,
- gathering critical information related to school and classroom behaviors, and
- designing strategies for managing daily classroom life.

Although primary caregivers and parents have the most complete information about their children, teachers see the student in a different environment. Teacher input of this nature is required to develop a successful Individualized Education Plan (IEP).

We will be collecting data for students ages 3 years 0 months through 11 years 11 months from across the United States from mid-September until late October. The person completing the behavior scale must be the classroom teacher of the student. The questionnaire will take approximately 15 to 20 minutes for the teacher to complete.

We will also be collecting a parent questionnaire as a validity measure for some non-clinical students and all clinical students (both the examiner and the parent will be compensated for this additional questionnaire).

Study Information and Payment Information are listed on the back of this page or page 2. If you received a fax or an e-mail that information can be found on page 2.
Classroom Questionnaire
Standardization Phase

Study Information

Standardization Study
This study is for students 3 years 0 months through 11 years 11 months. Students should be typically developing. The teacher must complete one (1) Classroom Questionnaire per student.

Autism/ADHD/Asperger’s Studies
Students in this study should be between the ages of 3 years 0 months through 11 years 11 months. Students should be diagnosed with Autism, ADHD, or Asperger’s disorders. The teacher should be either a special education teacher or a resource teacher. The teacher must complete one (1) Classroom Questionnaire and the parent or caregiver must complete one (1) Classroom Questionnaire.

Test/Retest Study
This study is for students 3 years 0 months through 11 years 11 months. Students must be typically developing. The teacher will complete two (2) Classroom Questionnaires 2-14 days apart.

Validity Study
This study is for students 3 years 0 months through 11 years 11 months. Students should be typically developing. The teacher will complete one (1) Classroom Questionnaire and the parent or caregiver will complete one (1) Classroom Questionnaire.

<table>
<thead>
<tr>
<th>Study</th>
<th>Teacher Time</th>
<th>Teacher Payment</th>
<th>Parent Time</th>
<th>Parent Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardization Study</td>
<td>15—20 Min.</td>
<td>$10</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<td>Autism/ADHD/Asperger’s Study</td>
<td>15—20 Min.</td>
<td>$10 for Teacher Form &amp; $10 for Parent Form</td>
<td>15—20 Min.</td>
<td>$10</td>
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<tr>
<td>Test/Retest Study</td>
<td>30—40 Min.</td>
<td>$10 for each of the Teacher Forms</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<td>Validity Study</td>
<td>15—20 Min.</td>
<td>$10 for Teacher Form &amp; $10 for Parent Form</td>
<td>15—20 Min.</td>
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Payment Information (per valid case)
Please note that the Autism, ADHD, Asperger’s, and Validity study cases will not be valid without the parent form.
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Please print your full and complete mailing address. Abbreviations in the address can lead to shipping difficulties with test kits and supplies. We cannot accept P.O. Box addresses. Thank you for your cooperation.

Name ____________________________________________________________
Address: ____________________________ City ________________ State ______ Zip _________
Name of school district or facility ____________________________________________
Profession ____________________________ Day phone ____________________________
Evening phone _________________________ Fax ____________________________
Email _______________________________ Can you receive email attachments? __________
How do you prefer to be contacted?
  Daytime phone _________ Evening phone _________ Fax _________ Email _________

Who Referred You? ______________________________________________________________________________________

It is important that we hear from you, even if you have decided not to participate. Please fax the completed form to 1.800.524.4124 as soon as possible. Should you have questions, please call 1.800.854.6434 or send an email to david_martinez01@harcourt.com.

Please indicate by a check mark your decision related to enrollment. Should you elect to participate, please include your signature in the space provided, choose a payment option and fill out the back of this page.

YES: ______ If selected, I will participate as an examiner in the Classroom Questionnaire standardization study. I fully understand that signing this form indicates that I have read the information about this project, and agree to participate as an examiner in accordance with all terms relating to this research study.
I understand this includes children ages 3 years 0 months to 11 years 11 months. Harcourt Assessment, Inc. will provide all test materials.

Signature ________________________________________________________________

NO: ______ I do not wish to participate as an examiner in the Classroom Questionnaire standardization study.

Payment Selection (Choose One)

__ Incentives will go to the Teacher __ Incentives will go to the School (complete the information below)
Payment method __ Check Payment Method __ Check
  __ Harcourt Catalog Credit __ Harcourt Catalog Credit
Social Security Number (For Payment Purposes) ___________________ - ___________ - ___________
District/Facility Name ______________________________________________________________________________________
Address __________________________________________________________________________________________________
City __________________________________________ State __________ Zip __________

If your payment will be going to a facility you will need to provide a W-9 for the facility.

Please Complete Page 2

Harcourt
Please indicate the clinical categories you will be able to test:
__ Autism                      __ ADHD                       __ Asperger’s Disorder

There will be an opportunity for you to earn additional incentives by participating in validity studies. Please indicate the validity studies you would like to participate in:
__ Test-Retest               __ Parent Form

Please indicate the clinical categories you will be able to test:
__ Autism                      __ ADHD                       __ Asperger’s Disorder

There will be an opportunity for you to earn additional incentives by participating in validity studies. Please indicate the validity studies you would like to participate in:
__ Test-Retest               __ Parent Form

Please indicate the education level of the children you have access to. Be very specific when listing number of years of schooling, especially when it is less than a high school diploma.

Please indicate the ethnicity of the children you have access to. (Check all that apply):
__ African American    __ Asian    __ Caucasian    __ Hispanic    __ Other (Includes Native American)

Note: For this project, we are using the primary caregiver’s education level.

Please indicate the parent education levels (PED) of the children you have access to. (Check all that apply)
__ PED 1: No HS Diploma or equivalent
__ PED 2: HS Diploma or equivalent
__ PED 3: Up through 3 years of college or tech. school, includes Associate’s Degree
__ PED 4: 4 or more years of college (with or without a degree)

Please indicate the clinical categories you will be able to test:
__ Autism                      __ ADHD                       __ Asperger’s Disorder

There will be an opportunity for you to earn additional incentives by participating in validity studies. Please indicate the validity studies you would like to participate in:
__ Test-Retest               __ Parent Form

Test candidate nominations
Please provide information on the candidates that you would like to test for this project. Feel free to send additional pages with names. Note: the greater the diversity in age, ethnicity and parent education, the greater the potential that you will be selected for the project and will be given reservations for your first choices.

Note: We need diversity in ethnic and socioeconomic backgrounds. Listing candidates does not guarantee that all names listed will be reserved. Do not test any child until you have received a reservation confirmation to do so.

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Primary Caregiver’s Education</th>
<th>Clinical Category</th>
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Clinical Categories: Autism, ADHD, Asperger’s Disorder
Education Level: Be very specific when listing number of years of schooling, especially when it is less than a high school diploma
Ethnicity: If multi-racial, please list all races

Questions?
1.800.854.6434 and Ask for a Classroom Questionnaire Team Member
Examiner Name:

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**Clinical Categories:** Autism, ADHD, Asperger’s

**Education Levels:**
- PED 1 – No High School Diploma
- PED 2 – High School diploma or equivalent
- PED 3 – Up to 3 years of college or tech school, including associates
- PED 4 – 4 or more years of college with or without a degree.

**Ethnicity:** If multi-racial please list all races.