

Behavior Observation Report (BOR) &/or Behavior Incident Report (BIR)

Select the appropriate option: BOR BIR*

*If BIR is selected, document the reason in the comment section at the end of the report and obtain signatures.

Child's Name: <u>Joey Lawrence</u>	Staff Name: <u>Erma Ellingson</u>	
Date: <u>07/20/2021</u>	Time of Occurrence: <u>10:45 AM</u>	
What Happened Before? <i>(from the child's perspective)</i>	Describe the Behavior Like a Camera Sees It <i>(form of behavior)</i>	What Happened Immediately After? <i>(from the child's perspective)</i>
Joey's teacher invites him to join in group time.	Joey resists, cries, and hits teacher.	Teacher moves away from Joey and allows Joey to select a different activity.
Why is this happening? (refer to <i>Toward a Better Understanding of Children's Behavior</i> for support, if needed)		
<input type="checkbox"/> Developmental Stage <input type="checkbox"/> Environment <input checked="" type="checkbox"/> Lack of Skills <input type="checkbox"/> Unmet Emotional Need	<input type="checkbox"/> Individual Differences <input type="checkbox"/> Temperament <input type="checkbox"/> Sensory Motor Capacities <input type="checkbox"/> Disability	<input type="checkbox"/> Health Issue <input checked="" type="checkbox"/> Express Emotion <input type="checkbox"/> Other: _____
Possible Motivation/Function (select all that seem possible)		
<input type="checkbox"/> Obtain Desired Item <input checked="" type="checkbox"/> Obtain Desired Activity <input type="checkbox"/> Gain Connection to Person <input type="checkbox"/> Gain Sensory Stimulation	<input checked="" type="checkbox"/> Express Emotion <input type="checkbox"/> Initiate Social Interaction <input checked="" type="checkbox"/> Avoid Adults <input type="checkbox"/> Avoid Sensory Stimulation	<input checked="" type="checkbox"/> Avoid Task <input type="checkbox"/> Avoid Peers <input type="checkbox"/> Get Help <input type="checkbox"/> Other: _____
Location of Occurrence (select only one)		
<input checked="" type="checkbox"/> Indoor Play Area <input type="checkbox"/> Outdoor Play Area <input type="checkbox"/> Bus	<input type="checkbox"/> Eating Area <input type="checkbox"/> Sleeping Area <input type="checkbox"/> Center: _____	<input type="checkbox"/> Bathroom/Changing Area <input type="checkbox"/> Other: _____
Activity or Routine (select only one)		
<input type="checkbox"/> Arrival/Drop-Off Time <input type="checkbox"/> Meals/Snack <input type="checkbox"/> Nap/Quiet Time <input type="checkbox"/> Self-Care	<input checked="" type="checkbox"/> Large Group <input type="checkbox"/> Inside Play <input type="checkbox"/> Outdoor Play <input type="checkbox"/> Small Group Activity	<input type="checkbox"/> Departure/Pick-Up Time <input type="checkbox"/> Transition <input type="checkbox"/> Individual Activity <input type="checkbox"/> Other: _____
Others Directly Involved (select all that apply)		
<input checked="" type="checkbox"/> Teacher/Primary Caregiver <input type="checkbox"/> Associate Teacher <input type="checkbox"/> Aide	<input type="checkbox"/> Family Member <input type="checkbox"/> Family Child Care Staff <input type="checkbox"/> Support/Administrative Staff	<input type="checkbox"/> Peers/Classmates Initials: _____ <input type="checkbox"/> Other: _____
What happened later? What did others do? (select all that apply, even if written above)		
<input checked="" type="checkbox"/> Acknowledged Distress <input checked="" type="checkbox"/> Offered Comfort <input type="checkbox"/> Tried Soothing Strategies <input type="checkbox"/> Peers Move Away <input type="checkbox"/> Used Words to Connect with Child	<input type="checkbox"/> Adult Moved Closer <input type="checkbox"/> Acknowledged Feelings <input type="checkbox"/> Visual Reminder (first/then, visual cue) <input checked="" type="checkbox"/> Redirection <input type="checkbox"/> Time with Adult	<input type="checkbox"/> Physical Guidance <input type="checkbox"/> Family Contact <input checked="" type="checkbox"/> Social-Emotional Teaching Strategy (describe): Second-Step <input checked="" type="checkbox"/> Other: Teacher moved away

Comments (include strengths as well as setting events (if known)): BIR due to Supervisor's Report of Accident

All BIRs must be reviewed & signed by HT/SS and sent to Area Manager for approval prior to reviewing with parent. Parent/guardian signature will be obtained as acknowledgment of Behavior Incident. If the signature cannot be obtained quickly enough, staff can review the BIR with the parent (initial below) and retrieve signature later. The completed BIR will be scanned to Dis./MH Dept. within 48 hours of incident. Signatures are not required on BORs. Refer to [SOP 5.3.24.1 Behavior Incidents](#) for more information.

SS/HT Signature: Betty Smith

Parent/Guardian Signature: Donna Lawrence

I have reviewed with the parent/guardian (initial): EE Reviewed: In-Person Phone Other: _____

Behavior Observation Report (BOR) &/or Behavior Incident Report (BIR)

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Child's Name: Thuy Ly	Staff Name: Erma Ellingson	
Date: 07/20/2021	Time of Occurrence: 9:45 AM	
What Happened Before? (from the child's perspective)	Describe the Behavior Like a Camera Sees It (form of behavior)	What Happened Immediately After? (from the child's perspective)
Peer is playing with a toy train. Thuy reaches for the train and says, "please". Peer turns away and says, "no".	Thuy hits peer and grabs the train.	Peer begins crying and walks away. Thuy begins playing with the train.
Why is this happening? (refer to <i>Toward a Better Understanding of Children's Behavior</i> for support, if needed)		
<input type="checkbox"/> Developmental Stage <input type="checkbox"/> Environment <input checked="" type="checkbox"/> Lack of Skills <input type="checkbox"/> Unmet Emotional Need	<input type="checkbox"/> Individual Differences <input type="checkbox"/> Temperament <input type="checkbox"/> Sensory Motor Capacities <input type="checkbox"/> Disability	<input type="checkbox"/> Health Issue <input type="checkbox"/> Express Emotion <input type="checkbox"/> Other: _____
Possible Motivation/Function (select all that seem possible)		
<input checked="" type="checkbox"/> Obtain Desired Item <input type="checkbox"/> Obtain Desired Activity <input type="checkbox"/> Gain Connection to Person <input type="checkbox"/> Gain Sensory Stimulation	<input type="checkbox"/> Express Emotion <input type="checkbox"/> Initiate Social Interaction <input type="checkbox"/> Avoid Adults <input type="checkbox"/> Avoid Sensory Stimulation	<input type="checkbox"/> Avoid Task <input type="checkbox"/> Avoid Peers <input type="checkbox"/> Get Help <input type="checkbox"/> Other: _____
Location of Occurrence (select only one)		
<input checked="" type="checkbox"/> Indoor Play Area <input type="checkbox"/> Outdoor Play Area <input type="checkbox"/> Bus	<input type="checkbox"/> Eating Area <input type="checkbox"/> Sleeping Area <input type="checkbox"/> Center: _____	<input type="checkbox"/> Bathroom/Changing Area <input type="checkbox"/> Other: _____
Activity or Routine (select only one)		
<input type="checkbox"/> Arrival/Drop-Off Time <input type="checkbox"/> Meals/Snack <input type="checkbox"/> Nap/Quiet Time <input type="checkbox"/> Self-Care	<input type="checkbox"/> Large Group <input checked="" type="checkbox"/> Inside Play <input type="checkbox"/> Outdoor Play <input type="checkbox"/> Small Group Activity	<input type="checkbox"/> Departure/Pick-Up Time <input type="checkbox"/> Transition <input type="checkbox"/> Individual Activity <input type="checkbox"/> Other: _____
Others Directly Involved (select all that apply)		
<input type="checkbox"/> Teacher/Primary Caregiver <input type="checkbox"/> Associate Teacher <input type="checkbox"/> Aide	<input type="checkbox"/> Family Member <input type="checkbox"/> Family Child Care Staff <input type="checkbox"/> Support/Administrative Staff	<input checked="" type="checkbox"/> Peers/Classmates Initials: JD <input type="checkbox"/> Other: _____
What happened later? What did others do? (select all that apply, even if written above)		
<input type="checkbox"/> Acknowledged Distress <input type="checkbox"/> Offered Comfort <input type="checkbox"/> Tried Soothing Strategies <input checked="" type="checkbox"/> Peers Move Away <input type="checkbox"/> Used Words to Connect with Child	<input type="checkbox"/> Adult Moved Closer <input type="checkbox"/> Acknowledged Feelings <input type="checkbox"/> Visual Reminder (first/then, visual cue) <input type="checkbox"/> Redirection <input type="checkbox"/> Time with Adult	<input type="checkbox"/> Physical Guidance <input type="checkbox"/> Family Contact <input type="checkbox"/> Social-Emotional Teaching Strategy (describe): _____ <input checked="" type="checkbox"/> Other: Obtained item

Comments (include strengths as well as setting events (if known)): _____

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SS/HT Signature: _____ Parent/Guardian Signature: _____

I have reviewed with the parent/guardian (initial): _____ Reviewed: In-Person Phone Other: _____

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Child's Name: _____	Staff Name: _____	
Date: _____	Time of Occurrence: _____	
What Happened Before? <i>(from the child's perspective)</i>	Describe the Behavior Like a Camera Sees It <i>(form of behavior)</i>	What Happened Immediately After? <i>(from the child's perspective)</i>
Why is this happening? (refer to <i>Toward a Better Understanding of Children's Behavior</i> for support, if needed)		
<input type="checkbox"/> Developmental Stage <input type="checkbox"/> Environment <input type="checkbox"/> Lack of Skills <input type="checkbox"/> Unmet Emotional Need	<input type="checkbox"/> Individual Differences <input type="checkbox"/> Temperament <input type="checkbox"/> Sensory Motor Capacities <input type="checkbox"/> Disability	<input type="checkbox"/> Health Issue <input type="checkbox"/> Express Emotion <input type="checkbox"/> Other: _____
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Location of Occurrence (select only one)		
<input type="checkbox"/> Indoor Play Area <input type="checkbox"/> Outdoor Play Area <input type="checkbox"/> Bus	<input type="checkbox"/> Eating Area <input type="checkbox"/> Sleeping Area <input type="checkbox"/> Center: _____	<input type="checkbox"/> Bathroom/Changing Area <input type="checkbox"/> Other: _____
Activity or Routine (select only one)		
<input type="checkbox"/> Arrival/Drop-Off Time <input type="checkbox"/> Meals/Snack <input type="checkbox"/> Nap/Quiet Time <input type="checkbox"/> Self-Care	<input type="checkbox"/> Large Group <input type="checkbox"/> Inside Play <input type="checkbox"/> Outdoor Play <input type="checkbox"/> Small Group Activity	<input type="checkbox"/> Departure/Pick-Up Time <input type="checkbox"/> Transition <input type="checkbox"/> Individual Activity <input type="checkbox"/> Other: _____
Others Directly Involved (select all that apply)		
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Comments (include strengths as well as setting events (if known)): _____

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SS/HT Signature: _____ Parent/Guardian Signature: _____

I have reviewed with the parent/guardian (initial): _____ Reviewed: In-Person Phone Other: _____

Teacher's Support Planning Sheet

Once complete, email to Site Supervisor or Head Teacher for review. The Site Supervisor or Head Teacher will then email to Area Manager.

Child's Name: _____	Routine: _____	Function: _____
Teacher/Primary Caregiver Name: _____		
What happened just before? (from the child's perspective)	What behavior(s) occurred? (like a camera would see it)	What happened just after? (from the child's perspective)
Setting Event?		
What can I do to prevent the problem?	What new or replacement skills should I teach or practice?	How do I respond to new behavior <u>and</u> what can I do if the problem behavior occurs?