Early Learning Coalition of Pinellas County, Inc.

Child Name: _____

Teacher: _____

SUPPORTIVE INTERVENTION SERVICES

Behavior Checklist

Use this form to check off how many times you see a specific behavior occurring in your care ***for at least 5 days***. This is required to determine the appropriate plan of action.

Day: _____

Time	Hit	Push	Scream	Tantrum	Throw	Bite	Refuse Teacher	Kick	Spit	Run Away	Hurt Self	Curse	Activity at time of incident: nap time, circle time, outdoor play, arrival, etc.
7-8													
8-9													
9-10													
10-11													
11-12													
12-1													
1-2													
2-3													
3-4													
4-5													
5-6													

Total Incidents: _____ Notes: (child's family changes, teacher's attempted interventions, schedule changes, weather, etc.)