**School Anxiety - Parent Checklist**

Name of Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **YES** | **NO** | **N/A** | **Comments** |
| **Attendance** |  |  |  |  |
| Reluctance to leave the house in the mornings |  |  |  |  |
| Late for school |  |  |  |  |
| Absent for part or whole days |  |  |  |  |
| **Environmental** |  |  |  |  |
| Significant life events (e.g. moving house/school, parental separation, additions to family, death of a pet or loved one) |  |  |  |  |
| Young person living in more than one home/temporary accommodation |  |  |  |  |
| Parental involvement with education (e.g. homework, parent teacher meetings, good communication with school) |  |  |  |  |
| Practical/financial challenges in getting to school |  |  |  |  |
| **Learning Needs** |  |  |  |  |
| Inability to problem solve |  |  |  |  |
| Organisational difficulties |  |  |  |  |
| Homework not done or incomplete on a regular basis |  |  |  |  |
| Difficulties working under pressure/processing difficulties |  |  |  |  |
| Specific learning difficulty – please specify |  |  |  |  |
| Not achieving learning potential |  |  |  |  |
| Avoidance of particular school activities/subjects |  |  |  |  |
| **Social** |  |  |  |  |
| Bullying |  |  |  |  |
| Fall out with friends/difficulties with peer relationships |  |  |  |  |
| Social communication difficulties |  |  |  |  |
| Not independent for age |  |  |  |  |
| Struggles during unstructured times |  |  |  |  |
| Lack of active engagement in social and leisure activities |  |  |  |  |
| **Emotional Wellbeing** |  |  |  |  |
| Often appears tired |  |  |  |  |
| Often appears to lack interest/motivation |  |  |  |  |
| Demonstrates low self-esteem |  |  |  |  |
| Shy, quiet or passive |  |  |  |  |
| Appears worried or anxious |  |  |  |  |
| Displays challenging behaviours |  |  |  |  |
| Lack of involvement in school life |  |  |  |  |
| **Physical Wellbeing** |  |  |  |  |
| Has/has had a serious illness or medical condition |  |  |  |  |
| Complains of sickness or headaches |  |  |  |  |
| Rapid weight gain or loss |  |  |  |  |
| Changes in eating habits |  |  |  |  |