MENTAL STILLNESS PROJECT
Teacher Initial REGISTRATION Form

Name Teacher (required) _____

Teacher Email (required) _____

Teacher Phone (required) _____

Name of School (required) _____

City (required) _____ State (required) _____

Mental Stillness REGISTRATION Teacher ID Number _____

Mental Stillness REGISTRATION School ID Number _____

Teacher's Name_____ Class Name_____

TEACHER's REPORT

DATE Of SESSION _____ VIDEO MODULE USED_____

NUMBER OF STUDENTS PRESENT AT TODAY's SESSION (required) _____

TEACHER VIDEO QUALITY ASSESSMENT (LOW) **0-1-2-3-4-5-6-7-8-9-10** (HIGH)

TEACHER SESSION FEEDBACK from Today's Session

1 - degree to which class was **SETTLED?** 0-10
(0=not at all settled, 10=completely settled)_____**Score 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10**

2 - degree to which class was **FOCUSED?** 0-10
(0=not at all focused, 10=completely focused)_____**Score 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10**

3 - degree to which class was **ENGAGED?** 0-10
(0=not at all engaged, 10=completely engaged)_____**Score 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10**

STUDENT FEEDBACK REPORT from this group STUDENTS

1 - how many now feel **CALMER?** (number of hands up)_____**Number _____ YES (hands Up)**

2 - how many now feel **PEACEFUL?** (number of hands up)____**Number _____ YES (hands Up)**

3 - how many got some **MENTAL SILENCE?** (hands up)_____**Number _____ YES (hands Up)**

NB Please ensure you seek appropriate permissions and clearances consistent with your own school and Education Department policies.