

**Imagine...A School Without Bullying:  
A School Climate Approach to Bullying Prevention  
Training Feedback Form – DAY 1**

**1. What is your role in your school?**

- Administrator
  Classroom Teacher
  Other Member of the School Community  
 Please define: \_\_\_\_\_

**2. Please indicate to what extent you agree or disagree with the following statements.**

		Strongly Agree	Agree	Disagree	Strongly Disagree
a.	I understand the nature of bullying behaviour.				
b.	I understand the principles of bullying intervention/ prevention.				
c.	I have sufficient knowledge of the components of the manual.				
d.	I am familiar with the steps in the bullying prevention framework.				
e.	I understand how to respond to bullying both as an individual and as a school community.				
f.	I understand how to apply the steps in the framework in my school community.				
g.	I understand how classroom meetings contribute to a positive school climate.				
h.	I understand how to implement classroom meetings.				

**3. As a result of this training, do you feel you have enough familiarity and understanding of the bullying prevention framework to begin the work of engaging your school community?**

- Yes  
 No      If no, what was missing from the training?

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**4. What was most helpful about the training session?**

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**5. What was least helpful about the training session?**

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**6. What would you change to make the training session more helpful?**

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**7. Do you have any other feedback regarding the training session?**

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**8. Another training session is scheduled for later this school year. What activities do you think will be most useful for your school climate committee?**

- Discussion with other schools that are implementing their plan at the same time as you are
- Discussion with experienced peers
- More education re: particular topics e.g. classroom meetings, responding to bullying, formative discipline
- Discussion on tracking bullying behaviour, program evaluation and surveys
- Other:  
\_\_\_\_\_

**9. After attending this training session I feel (Check more than one if necessary):**

- |                                      |  |                                      |
|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Overwhelmed | <input type="checkbox"/> Confused      | <input type="checkbox"/> Bored       |
| <input type="checkbox"/> Challenged  | <input type="checkbox"/> Excited       | <input type="checkbox"/> Motivated   |
| <input type="checkbox"/> Confident   | <input type="checkbox"/> Well Prepared | <input type="checkbox"/> Discouraged |

**Thank-you for your feedback!**