N-O-T Participant List

School/Site:	
Facilitator Name:	

Sessions:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Dates:										

Please take attendance at the start of each session. This list will be kept confidential and is used for attendance purposes only. Please **do not** share this sheet with the American Lung Association, the school, site, or other individuals.

If a student discontinues the program, please indicate reason. After each name, there is a space for any notes or comments. Students leave the N-O-T program for many different reasons. Listed below are codes for the most common reasons:

1. Unable to get out of class	2. Transferred to another school	3. Reported that they "did not like" the program	4. Home schooled
5. Illness	6. Suspended	7. Expelled	8. Other (please explain)

Name:							**Initials:**			
Attendance:	1	2	3	4	5	6	7	8	9	10
Notes:										
Evaluations:	**About Me 1**			**About Me 2**			**Tell Us What You Think**			

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Attendance:	1	2	3	4	5	6	7	8	9	10
Notes:										
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N-O-T Facilitator Survey

Please answer the questions below. Your answers will be used to determine how N-O-T could be improved in future additions.

1.	**What is your gender?**	

2.	**County/State of employment?**	/

3. What type of position do you hold?

- ☐ Administrator (please specify job title):
- ☐ Faculty
- ☐ Staff (please specify job title):
- ☐ Other (please specify):

4.	**In what year were you trained as a N-O-T facilitator?**	

5.	**How many N-O-T groups have you conducted since you were trained?**	

6. What time of day do you typically conduct N-O-T groups?

	Rarely	Sometimes	Frequently	Always
Immediately before school	☐	☐	☐	☐
Immediately after school	☐	☐	☐	☐
During lunch	☐	☐	☐	☐
During study hall	☐	☐	☐	☐
During regular class schedule	☐	☐	☐	☐
On a weekday evening	☐	☐	☐	☐
On a weekend day	☐	☐	☐	☐
Other:	☐	☐	☐	☐

7. How often do you use each of these methods to promote N-O-T?

	Never	Rarely	Sometimes	Almost always	Always
Talk with students one-on-one	☐	☐	☐	☐	☐
Make PA announcements	☐	☐	☐	☐	☐
Distribute posters/flyers	☐	☐	☐	☐	☐
Make announcements in the classroom	☐	☐	☐	☐	☐
Talk to community businesses and organizations	☐	☐	☐	☐	☐
Talk to parents	☐	☐	☐	☐	☐
Encourage peer-to-peer recruitment	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

8. How often do you use the booster sessions?

☐ Never	☐ Rarely	☐ Sometimes	☐ Almost always	☐ Always

9. Generally speaking, how often is each of these items a barrier to delivering N-O-T?

	Never	Rarely	Sometimes	Frequently	Always
Insufficient administrative support	☐	☐	☐	☐	☐
Facilitator availability	☐	☐	☐	☐	☐
Not enough time in my schedule	☐	☐	☐	☐	☐
Skill to deliver N-O-T	☐	☐	☐	☐	☐
Do not believe that N-O-T would be useful in our setting	☐	☐	☐	☐	☐
Insufficient resources (materials, space)	☐	☐	☐	☐	☐
Not allowed to hold groups during school day	☐	☐	☐	☐	☐
Block scheduling	☐	☐	☐	☐	☐
Students not interested	☐	☐	☐	☐	☐
Students afraid to admit that they smoke	☐	☐	☐	☐	☐
Students are unwilling to admit that they smoke	☐	☐	☐	☐	☐
Students don't want peers to know they are joining a group	☐	☐	☐	☐	☐
Students don't want parents to know that they smoke	☐	☐	☐	☐	☐
Teachers are unwilling to release students from class	☐	☐	☐	☐	☐
Parents not supportive of youth quit efforts	☐	☐	☐	☐	☐
Parents not supportive of N-O-T	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

N-O-T About Me 1

Today's Date:		**Your Initials:**	___ ___ ___
School/Site:		**State:**	

Check or fill in the appropriate answers:

1.	**What is your gender?**	
2.	**What is your age?**	☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19
3.	**What grade are you in?**	☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

4.	**What is your race/ethnic group?** (Check all that apply)
	☐ Non-Hispanic White
	☐ Non-Hispanic African American
	☐ American Indian or Alaska Native
	☐ Asian American or Asian
	☐ Hispanic
	☐ Native Hawaiian/Pacific Islander
	☐ Other (please specify):

5.	**Have you smoked a cigarette at least once in the past 30 days?**	☐ Yes ☐ No
6.	**Have you smoked a cigarette on 20 or more days in the past 30 days?**	☐ Yes ☐ No
7.	**During the week (Monday thru Friday), about how many cigarettes do you smoke per day?**	

8.	**During the weekend (Saturday and Sunday), about how many cigarettes do you smoke per day?**	

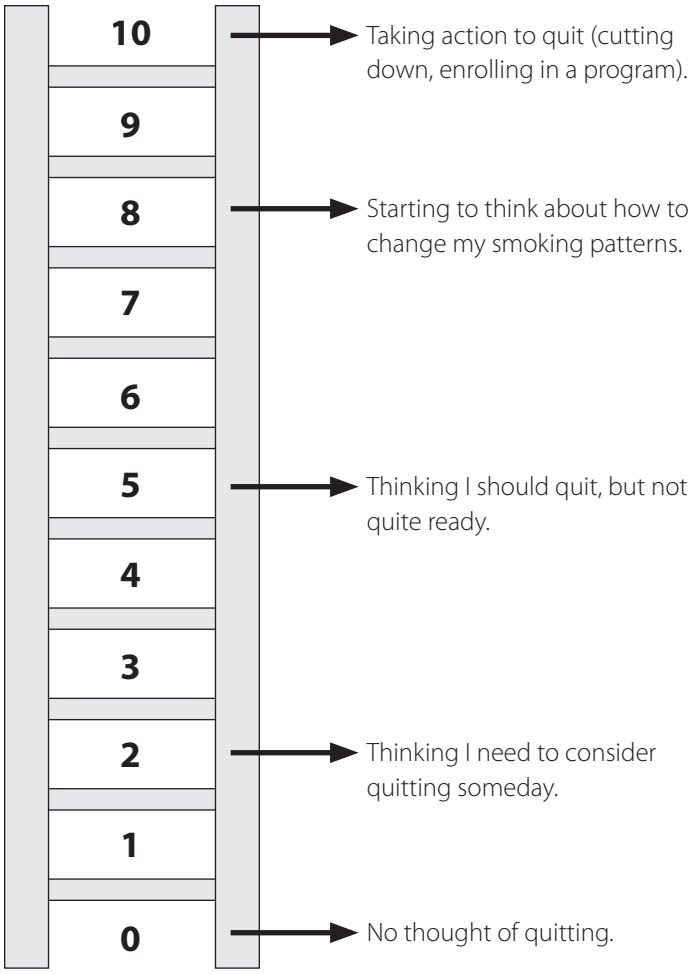
9. Right now, how would you rate your motivation to stop smoking cigarettes?

☐ None	☐ Low	☐ Medium	☐ High	☐ Very high

10. Right now, how would you rate your confidence in quitting smoking?

☐ None	☐ Low	☐ Medium	☐ High	☐ Very high

11. Each rung on the ladder below represents how various smokers are thinking about quitting. Circle the number that indicates how you feel now. Please circle only one number.



12. Which of the following statements best describes your attitude toward smoking cigarettes right now? (Check only one)

- ☐ I do not plan to quit smoking in the next six months.
- ☐ I plan to quit smoking in the next six months.
- ☐ I plan to quit within the next 30 days.
- ☐ I have made a serious quit attempt in the past six months.
- ☐ I quit less than six months ago.

13. How old were you when you smoked a whole cigarette for the first time? _____

14. How many times have you tried to quit smoking?

☐ None ☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7 or more

15. If you have tried to quit smoking, how did you try to quit? (Check all that apply)

- ☐ On my own
- ☐ In a group
- ☐ With N-O-T. If you have participated in this program before, when?
  Month: _____ Year: _____
- ☐ Nicotine replacement therapy (e.g., nicotine patch, nicotine gum)
- ☐ Other quit smoking medication like Zyban® or Chantix®
- ☐ Doctor or other healthcare provider
- ☐ Online/Internet program
- ☐ Telephone HelpLine or QuitLine
- ☐ Other (please specify):

16. **Do you live with someone who smokes?** (Check all that apply)

- ☐ Parent/guardian
- ☐ Sibling
- ☐ Other person (please specify):
- ☐ No one smokes in my household

17. **Do you have other important people in your life (that do not live with you) who smoke?** (Check all that apply)

- ☐ Close friend
- ☐ Boyfriend/girlfriend
- ☐ Family member
- ☐ Other (please specify):
- ☐ No one

18. **How did you learn about N-O-T?** (Check all that apply)

- ☐ Poster
- ☐ Friend
- ☐ Handout (flyer)
- ☐ Teacher
- ☐ School TV
- ☐ School nurse
- ☐ Sign-up table
- ☐ Incentives like pizza or prizes
- ☐ Other (please specify):

Please answer a few questions about your cigarette smoking habits.

19.	**Have you ever tried to quit but couldn't?**	☐ Yes	☐ No
20.	**Do you smoke now because it is really hard to quit?**	☐ Yes	☐ No
21.	**Have you ever felt like you were addicted to tobacco?**	☐ Yes	☐ No
22.	**Do you ever have strong cravings to smoke?**	☐ Yes	☐ No
23.	**Have you ever felt like you really needed a cigarette?**	☐ Yes	☐ No
24.	**Is it hard to keep from smoking in places where you are not supposed to (e.g., at school or in a store)?**	☐ Yes	☐ No

For the last four questions, think about times when you tried to stop smoking, or when you have not used tobacco for a while:

25.	**Did you find it hard to concentrate?**	☐ Yes	☐ No
26.	**Did you feel more irritable?**	☐ Yes	☐ No
27.	**Did you feel a strong need or urge to smoke?**	☐ Yes	☐ No
28.	**Did you feel nervous, restless, or anxious because you couldn't smoke?**	☐ Yes	☐ No

N-O-T About Me 2

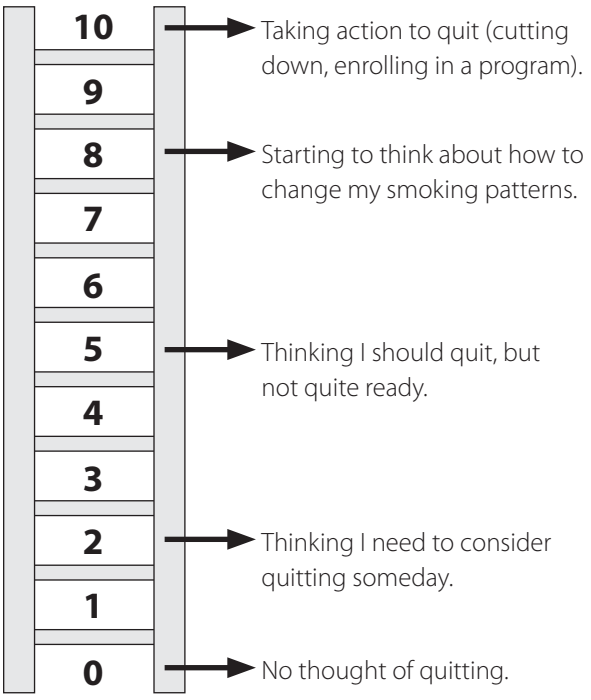
Today's Date:		**Your Initials:**	___ ___ ___

1.	**Are you still smoking any cigarettes?**	
	☐ No	**If you are not smoking,** how many days has it been since your last cigarette? (Enter number of days) _____ (now, skip to question 5.)
	☐ Yes	**If "Yes,"** answer questions 2–4.

2.	**During the week (Monday thru Friday), about how many cigarettes do you smoke per day?**	

3.	**During the weekend (Saturday and Sunday), about how many cigarettes do you smoke per day?**	

4. **Each rung on the ladder below represents how various smokers are thinking about quitting. Circle the number that indicates how you feel now. Please circle only one number.**



5. **Which of the following statements best describes your attitude toward smoking cigarettes right now?** (Check only one)

- ☐ I do not plan to quit smoking in the next six months.
- ☐ I plan to quit smoking in the next six months.
- ☐ I plan to quit within the next 30 days.
- ☐ I have made a serious quit attempt in the past six months.
- ☐ I quit less than six months ago.

Tell Us What You Think

Thank you for participating in the N-O-T program. Your opinion can help us improve this quit smoking program. Please take a few moments and fill out the questionnaire below.

1. **How important was the N-O-T program in helping you quit or reduce smoking?**

- ☐ Not at all important
- ☐ Somewhat important
- ☐ Moderately important
- ☐ Very important
- ☐ Extremely important

2. **What did you like *best* about the N-O-T program?** (Please print)

3. **What did you like *least* about the N-O-T program?** (Please print)

4. **Who was in your group?** (Check only one)

☐ All males ☐ All females ☐ Both males and females

5. **If you were in an all boys or all girls group, how important was it to you to have separate groups for males and females?**

- ☐ Not at all important
- ☐ Somewhat important
- ☐ Moderately important
- ☐ Very important
- ☐ Extremely important
- ☐ Not applicable, I was in a mixed group

6. **In what areas of your life (other than stopping or reducing smoking) was the program helpful?** (Check all that apply)

- ☐ Exercising more
- ☐ Getting better grades
- ☐ Going to school more often
- ☐ Eating better
- ☐ Making new friends
- ☐ Feeling better about myself
- ☐ Dealing better with stress
- ☐ Dealing better with family and friends
- ☐ Other (please specify):
- ☐ No other areas