FAMILY SCHOOL LIAISON PROGRAM
REFERRAL FORM

Student Name: _____

D.O.B.: Day _____Month_____Year_____ **Age:** _____ **Gender:** ___ M ___ F ___ X

Mailing Address: _____

Grade:_____ **School**: _____

Elementary/Homeroom Teacher's Name: _____

Referral Date: _____

Referred by: _____ **Phone:** _____

Referral Agency: _____

Guardian's name: _____

Guardian's phone: _____**(h)** _____**(w)** _____**(c)**

Is the student being referred for services identified in an IPP? yes or no

Date referral source contacted guardian:_____

If known, please list any other community agencies/services and contacts that are involved:

_____

Reason for Referral:

_____

_____

_____

_____

PLEASE NOTE THAT THE COMPLETED REFERRAL FORM MAY BE MADE AVAILABLE TO THE GUARDIAN.

This program is partially funded by Eastern Edge RCSD.

(The FSL Worker will notify the referral source when services have ended.)