Parent Referral Form

Please return to your student's counselor

Student Name: _____ Grade: _____ Student # _____

Parent Name _____ Contact #_____

- Perceived disability and impact on school success.

- Does your student have a medical diagnosis that would impact his/her school success?

- On a scale of 1-5 what is the impact of the disability on your student's school success?
  Low impact 1 2 3 4 5 High impact

  Please Explain:

- What is the average time spent on homework daily?

- What specific steps have you taken to help your child?

- Which teachers have you spoken with?

  What suggestions did you receive?

  Did they work?

- What additional help are you requesting (what services do you believe will help your child better succeed)?