

College Park High School
CARE Team - Counseling and Support Services

Please return completed form to Ms. Frank's box
Email: frankd@mdusd.org or phone x3203

NOTE: if you suspect Child Abuse or Neglect, notify CPS at (925) 646-1680

Staff Name: _____	Ext.: _____	Date: _____
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Name of Student: _____ Grade: _____

- General Education
 Special Education
 Section 504
 ELL

Name of Health Insurance (please inquire): _____

Is student aware that you are making this referral? Yes No

Has the family been informed that you are making this Referral? Yes No If so, who and what type of contact has been made?

Dangerous to self or others: Urgent / crisis situations must be reported to a school administrator immediately.
If students are in distress, contact a School Administrator and submit a Care Team referral.

Please check all that apply

CONCERNS	STUDENT STRENGTHS	PRIOR INTERVENTIONS
<input type="checkbox"/> Basic needs: food/clothing/shelter <input type="checkbox"/> Is frequently absent and/or tardy <input type="checkbox"/> Academic concerns / failing classes <input type="checkbox"/> Behavior concerns in classroom <input type="checkbox"/> Appears to abuse drugs or alcohol <input type="checkbox"/> Violent behavior – fighting <input type="checkbox"/> Has conflicts with other students or staff <input type="checkbox"/> Family/Friends/Relationship Concerns <input type="checkbox"/> Experienced trauma <input type="checkbox"/> Does not smile, laugh, or appear happy <input type="checkbox"/> Is easily angered, annoyed or upset <input type="checkbox"/> Gender / sexual identity concerns <input type="checkbox"/> Grief-related issue (describe below) <input type="checkbox"/> Victim of violence <input type="checkbox"/> Foster youth/may be foster youth <input type="checkbox"/> Homeless youth or family <input type="checkbox"/> Other: _____	<input type="checkbox"/> Artistic / creative <input type="checkbox"/> Academic talents (describe) <input type="checkbox"/> Articulate / verbal <input type="checkbox"/> Athletic / physically active <input type="checkbox"/> Sensitive / empathic <input type="checkbox"/> Is a good friend to others <input type="checkbox"/> Funny / sense of humor <input type="checkbox"/> Leader among peers <input type="checkbox"/> Positive relationships w/ adults <input type="checkbox"/> Supportive family / caregivers <input type="checkbox"/> Believes in self / confident <input type="checkbox"/> Asks for help / assistance <input type="checkbox"/> Other: _____ _____ _____ _____ _____	<input type="checkbox"/> Discussed your concerns with the student? <input type="checkbox"/> Offered extra academic assistance <input type="checkbox"/> Spoke with parents / caregivers <input type="checkbox"/> Met with parents / caregivers <input type="checkbox"/> Support calls / classroom observation <input type="checkbox"/> Has behavior contract <input type="checkbox"/> Previous referral to Coordinate Care Team <input type="checkbox"/> Discussed at Academy or Dept. meeting <input type="checkbox"/> Held SST / follow-up SST <input type="checkbox"/> Changed class schedule <input type="checkbox"/> Special Education Assessment in progress <input type="checkbox"/> SART meeting at school _____ <input type="checkbox"/> SARB Meeting at District Office _____ <input type="checkbox"/> Positive Behavior Team referral _____
		<u>ADDITIONAL SERVICES</u> Is the student and/or the family working with providers outside of school? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure Agency name: _____

Please describe your primary concern about this student and your reason for referral:

Interventions:

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