Margate School District

Child Study Team

101 N. Haverford Ave., Margate, NJ 08402
Phone: 609-822-2080 ext. 352 *Fax:* 609-822-3489

PARENT REFERRAL FORM

CHILD'S NAME:_____ DOB:_____ GRADE:_____

ADDRESS:_____ HOME PHONE:_____

_____ CELLPHONE #:_____

CHILDS GENDER: Male / Female

CHILDS ETHNICITY: Hispanic / American Indian / Alaskan / Asian / Black / Pacific Islander / White

LANGUAGE SPOKEN AT HOME:_____ NATIVE LANGUAGE:_____

MOTHER:_____ FATHER:_____
First Last Name *First Last Name*

ADDRESS, IF ***DIFFERENT*** FROM ABOVE:
Mother *Father*

_____ _____

_____ _____

CELL#: _____ CELL#:_____

WORK#: _____ WORK#:_____

PARENT(S)/GUARDIAN **CONCERNS:** *(Please explain reason for wanting your child evaluated).*

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_____ _____
Parent Signature ***Date*** ***Parent Signature*** ***Date***