



Compton Unified School District

Child Welfare and Attendance

417 W. Alondra Blvd. Compton, CA 90220

Tel:(310) 639-4321, Ext. 46523

- ☐ Crisis Referral
- ☐ Therapy Referral
- ☐ PMRT
- IEP (Please Check)
☐ Yes ☐ No
- AB490 (Please Check)
☐ Yes ☐ No

Site-Based Intervention Services Referral Form

(Please scan and email to referral@compton.k12.ca.us)

School Site: _____ Date of Request: _____

Student's

Name: _____ DOB: _____ Age: _____ Gender: _____ Grade: _____

Student's

Address: _____ Race/Ethnicity: _____

Street

City

State

Zip

Parent's/Guardian's Name: _____ Primary Language: _____

Phone No: _____ (☐Home ☐Cell) Email: _____

Medi-Cal Eligible: ☐Yes ☐No

McKinney -Vento: ☐Yes ☐No

Description of Concern/Problem: _____

Pre-Referral Intervention:

Hawthorne Manual Used

Page #

Intervention #

1. _____

2. _____

3. _____

4. _____

SSMT Meeting(s):

☐Yes ☐No Dates: _____

**Informed Consent and Release of Student Information/Consentimiento Parental para la
Divulgacion de Dtos Estudiantiles**

I am the parent/guardian of _____. I authorize my child to participate in Compton Unified School District's Therapeutic Intervention Services. I also authorize CUSD to release information about my child to an intervention staff person(s) and/or intervention agency, either within or outside of CUSD (for the sole purpose of assisting my child), effective this date. I am aware that I have the right, under California laws, to confidentiality and to withdraw this consent at any time. I understand that if my child's referral is forwarded to an agency affiliated with the Department of Mental Health and/or the Department of Health Care Services, I will be asked to provide additional information.

My child ☐ is / ☐ is not currently working with an agency. (Name of Agency_____)

Yo soy el padre/madre/tutor legal de _____. Yo autorizo al Distrito Escolar Unificado de Compton que den información sobre mi hijo/a al persona/s de intervenciones y/o agencia/s de intervención, ya sea dentro o fuera de CUSD (con el solo propósito de ayudar a mi hijo/a), tomando en efecto ahora. Yo tengo conocimiento de mis derechos, bajo la ley de California, a confidencialidad y puedo retractarme a este consentimiento en cualquier momento. Yo entiendo que si mi hijo/a es referido a una agencia afiliada con el departamento de Salud Mental y/o departamento de Servicios de Salud, se me pedirá proveer información adicional.

Mi hijo/a ☐ esta con/☐ no está actualmente con ninguna agencia.
(_____ nombre de la agencia)

Signature/Firma: _____ Relation/Relacion _____ Date/Fecha _____

Student Signature (Self Referral) _____ Date _____

Administrator's/Designee's Signature: _____ Title: _____ Ext: _____

*****For Pupil Services Department – Child Welfare and Attendance - Use Only. *****

<u>Dispersed To</u> ☐ Behavior Therapist _____ ☐ Family Therapist _____ ☐ Dept. Mental Health _____ ☐ Intervention Agency _____ ☐ Other _____ Date _____ CWA Staff Initials _____ Date _____ CWA Staff Initials _____	<u>Agency/Provider Use Only</u> ☐ Clinician Assigned _____ ☐ Clinician's Contact Info _____ (Cell) _____ (Office) _____ (Email) ☐ Unable to open case (describe reason) _____ _____ Signature _____ Date _____
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