Peru Central School District | Preventive School Agency Partnership

PSAP REFERRAL

Student's name _____ Date of birth_____

Grade _____ Teacher's name _____

Parent(s)/guardian(s)_____

Address _____

Telephone number (home)_____Work _____ Cell_____

Please check services presently being provided:

__O.T. _____P.T. __Speech _____BHSN Therapist
__P.SAP _____Counseling __Special Education _____Homework
__Remedial Education _____YMCA After School Program _____Club Other:

Reason for referral (please be specific):

_____
_____
_____
_____
_____

What intervention has the school taken with the child and/or parent(s)/guardian(s) and how have these interventions been addressed with parent(s)/guardian(s)?

_____
_____
_____
_____
_____

Are the parent(s)/guardian(s) aware of this referral and what was their response to problems/concerns?_

_____
_____
_____
_____
_____
_____

Release form for DSS and PSAP signed by parent? __ Yes or _____ No.

_____ _____ _____ _____
Signature of Referral Source Date Signature of Principal Date

Copies distributed/scanned to: