Cumberland County
Children & Youth Services

SCHOOL REQUEST FOR SERVICE

NOTE: This form is for school attendance referrals ONLY. Please fill in all blanks. Per mandate if there are concerns of child abuse or neglect, CALL CHILDLINE IMMEDIATELY (1-800-932-0313).

1. REASON FOR REFERRAL

_____
_____
_____
_____

2. SUBJECT

FULL NAME_____DOB_____
ADDRESS_____
CUSTODY_____
POB_____TELEPHONE #_____
S.S.#_____RACE_____IEP_____
SCHOOL DISTRICT_____BUILDING_____
GRADE_____TYPE OF CLASS_____IEP_____
DEVELOPMENTAL HISTORY (cite significant problems)

A. MEDICAL_____
B. PHYSICAL_____
C. MENTAL_____

NAMES/ADDRESSES OF PHYSICIANS, DENTISTS, ETC. WHERE CHILD HAS BEEN SEEN_____

_____
_____
SAP REFERRAL MADE_____DATE_____
RECOMMENDATIONS_____
_____
SCHOOL or other PSYCHIATRIC EVALUATIONS_____
DATE_____DIAGNOSIS_____
RECOMMENDATION/TREATMENT_____
_____
_____
_____
SCHOOL ATTENDANCE IMPROVEMENT PLAN (SAIP) MEETING DATE_____
PARTICIPANTS AT SAIP MEETING_____
RECOMMENDATIONS OF SAIP_____
_____
_____
_____
_____
**PLEASE ATTACH COPY OF SAIP TO THIS REFERRAL

3. SIBLINGS (* indicate if they have truancy problems)

NAME	DOB	ADDRESS/CUSTODY	SCHOOL DISTRICT/GRADE

4. MOTHER

FULL NAME_____ DOB_____
ADDRESS_____ POB_____
_____ TELEPHONE#_____
DATE OF DEATH/CAUSE_____ WORK #_____
S.S.#_____ RACE_____ RELIGION_____
SIGNIFICANT MEDICAL PROBLEMS_____
COURT RECORD_____
EDUCATION/HIGHEST GRADE COMPLETED_____
PRESENT EMPLOYMENT (include where employed, hours of employment)_____
_____
_____
MARITAL HISTORY (include names of previous spouses, present marital status)_____

5. FATHER

FULL NAME_____ DOB_____
ADDRESS_____ POB_____
_____ TELEPHONE #_____
DATE OF DEATH/CAUSE_____ WORK #_____
S.S.#_____ RACE_____ RELIGION_____
SIGNIFICANT MEDICAL PROBLEMS_____
COURT RECORD_____
EDUCATION/HIGHEST GRADE COMPLETED_____
PRESENT EMPLOYMENT (include where employed, hours of employment)_____
_____
_____
MARITAL HISTORY (include names of previous spouses, present marital status)_____
_____

6. STEP PARENT/LIVE-IN PARAMOUR (circle one)

FULL NAME_____ DOB_____
ADDRESS_____ POB_____
_____ TELEPHONE #_____
DATE OF DEATH/CAUSE_____ WORK #_____
S.S.#_____ RACE_____ RELIGION_____
SIGNIFICANT MEDICAL PROBLEMS_____
PRESENT EMPLOYMENT (include where employed, hours of employment)_____
_____
_____

7. OTHER PEOPLE IN THE HOME AND RELATIONSHIP TO SUBJECT(S)

_____
_____
_____
_____
_____

8. EXTENDED FAMILY RESOURCES

_____
_____

9. OTHER AGENCIES INVOLVED WITH THE FAMILY

_____
_____
_____
_____

10. ACTIONS TAKEN BY THE SCHOOL (include when the school began requiring medical excuses, when the parents were cited, etc.). Attach full school attendance records (current year and all years enrolled), the School Attendance Improvement Plan developed by the school and family, and the most recent report card.

Please check off all services referred to parents and child:

_____Detention	_____Support Groups
_____In-School Suspension	_____Family Group Conference Referral
_____Out-of-School Suspension	_____Drug and Alcohol Evaluation
_____District Justice citations	_____School Attendance Improvement Plan meeting this year
_____Counseling in School	_____Student Assistance Team
_____Parent/Child Conferences	_____On Medical Excuse
_____Home Visits	_____Referral to Counselor in Community
_____Educational Placement Testing	_____Alternative Education Program
_____CAIU Placement	_____Other: _____

11. ADDITIONAL COMMENTS (use back of page if necessary)

12. BUILDING CONTACT PERSON

NAME/REFERRAL SOURCE _____

_____
SIGNED

_____
SCHOOL DISTRICT

_____
TELEPHONE #

_____
DATE

FORWARD TO:
Cumberland County Children and Youth Services
Dennis Marion Public Service Building
16 W. High Street, Suite 200
Carlisle, PA 17013-2961
cccy@cumberlandcountypa.gov
Telephone: (717) 240-6120 or 1-888-697-0371, Ext. 6120
Fax: (717) 240-6433

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