

# PARENT/GUARDIAN REFERRAL - INDIVIDUAL STUDENT COUNSELING



Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Teacher \_\_\_\_\_ Date \_\_\_\_\_

Referring Parent/Guardian \_\_\_\_\_

Relationship with Student \_\_\_\_\_ Phone/Email \_\_\_\_\_

Please describe the specific reason for referring your child. Include any concerns relating to academic progress, behavior, social skills, self-esteem, etc., that you feel are important. (Use the back if needed)

Please check any of the following behaviors/concerns that apply to your child's particular situation.

<input type="checkbox"/> grades	<input type="checkbox"/> confidence	<input type="checkbox"/> class work	<input type="checkbox"/> anger management
<input type="checkbox"/> fighting	<input type="checkbox"/> grief/loss	<input type="checkbox"/> absences	<input type="checkbox"/> adjustment/transition
<input type="checkbox"/> hygiene	<input type="checkbox"/> always tired	<input type="checkbox"/> homework	<input type="checkbox"/> negative attitude
<input type="checkbox"/> anxiety	<input type="checkbox"/> withdrawn/shy	<input type="checkbox"/> sadness	<input type="checkbox"/> cries easily
<input type="checkbox"/> bullying	<input type="checkbox"/> family concerns	<input type="checkbox"/> manipulative	<input type="checkbox"/> friends/peer issues
<input type="checkbox"/> behavior	<input type="checkbox"/> loneliness	<input type="checkbox"/> self-control	<input type="checkbox"/> social skills

What do you consider to be your child's strengths?

- Is your child aware of this referral? Yes No

Please list any goals you think your child should work on during the session(s).  
(Use the back if needed)

Comments. *Please include anything that may be helpful for me to know ahead of time and to better assist your child.* (Use the back if needed)

Please turn this referral into your child's homeroom teacher, and they will get it to the School Counselor. Thank you!☺