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| **Dorchester County Public Schools** **Request for Assistance** **School Site:** North Dorchester High School  |

**\*\*\*Confidential: please do not leave out for others to read\*\*\***

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| **Student:**  | **Grade**  | **Gender**  | **DOB** | **Ethnicity**  |
| **Parent/Caregiver** | **Home Language** | **Telephone Number** |
| **Name of Person Making Request** | **Your title/Position** | **Classroom or Telephone Ext.** |
| 1. **Student’s Strengths**
 | **2. Your Concerns about Student** | **3. Prior Interventions** |
| * Able to problem solve
* Articulates feelings/needs
* Asks for help
* Attentive in class
* Cooperates with others
* Demonstrates sense of humor
* Enjoys math
* Enjoys reading
* Follows instructions
* Helpful to others
* Listens well
* Makes/maintains friendships
* Negotiates/compromises
* Participates in class
* **Other:**

 | **Please check and provide additional details:*** **Academic**
* **Attendance**
* **Emotional/Behavioral**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* **Family/home**
* **Physical Health/Medical**
* **Other**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | * Behavioral Interventions
* Classroom modifications
* Instructional modifications
* Met with student
* Offered tutoring/after-school program
* Spoken to/met with parent/caregiver
* **Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please describe your interventions including length of time tried:****Describe the Student’s response to the interventions implemented:** |

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*Complete if student is referred to SST\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

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| **4. Student Profile Section (Counselor/SST Team to complete):** |
| **MSA Scores (two previous years)** | **Reading** | **Math** | **Support services student is currently receiving:** |
|  |  |  | * After-school prog.
* Tutoring
* IEP
* Mental Health
 | * Mentoring
* 504 Plan
* Physical Health
 | * ELL
* Peer Resources
* Foster Care
* Other:
 |
|  |  |  |
| **Health Most recent physical Exam:\_\_\_\_\_\_\_\_\_\_\_****Immunizations: Complete Incomplete:\_\_\_\_\_****Chronic health conditions?** | ScreeningVisionHearing | **Date** | **Status – Pass/Fail** | **Follow Up required?** |

**5. Date family notified re: referral to SST:\_\_\_\_\_\_\_\_\_\_\_\_ Results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*Feedback to Referring Person\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

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| **Date Referral Processed:** | **Primary Contact Person:** |
| **Action Items Planned****1.** |  |
| **2.** |  |
| **3.** |  |

**Distribution:** Original – Cum Folder Copies: Primary Contact Person & Referral Source