Washington Grade School District #52

Office of the Superintendent
303 Jackson St. - Washington, IL 61571

Ph. (309) 444-4182 Fax (309) 444-8538

SCHOOL COUNSELOR REFERRAL FORM

Date:_____ Submitted by:_____
Student Name:_____ Grade:____ Teacher:_____
Address:_____
Parent/Guardian:_____ Home Phone:_____ Cell:_____
Parent/Guardian:_____ Home Phone:_____ Cell:_____
Email Address (if you prefer to be contact via email):_____
Siblings (Names and Ages):_____
Medications:_____

Reason for Request:_____
_____
_____

Specific behavior/concerns indicating need for services (Please give examples):
_____
_____
_____

What interventions have been attempted with this student?_____
_____
_____

Have parents/gaurdians been contacted regarding the problems: ___Yes ___No

Please state convenient times for this student to be seen:_____
_____

Additional Comments:_____
_____

* Parental permission must be obtained before a referral is made to the School Counselor (See reverse side).