

SEDGWICK COUNTY AREA EDUCATIONAL SERVICES INTERLOCAL COOPERATIVE

REFERRAL FORM - ESC-302
HOME/SCHOOL COORDINATOR SERVICES

Complete all sections (please do not use pencil), retain a copy for your file, then send referral and consent to: Director, Special Education Office, 620 Industrial, P.O. Box 760, Goddard, KS 67052.

Student's Name: _____ DOB: _____ Age: _____ Gr: _____ Sex: _____

School: _____ Principal: _____ Teacher: _____

Student Residing with: Both Parents: _____ Mother: _____ Father: _____ Other: _____

Father _____ Address _____ City _____ Zip _____
Occupation _____ Bus. Phone _____ Home Phone _____
Step-Mother _____ Occupation _____ Bus. Phone _____

Mother _____ Address _____ City _____ Zip _____
Occupation _____ Bus. Phone _____ Home Phone _____
Step-Father _____ Occupation _____ Bus. Phone _____

Names of Siblings	Age	Grade	Names of Siblings	Age	Grade

Reason for Referral: (Please check any that apply)
_____ CURRENTLY IN SP. ED. (If yes, what Excep. _____) _____ IN PREASSESSMENT
_____ EMERGENCY REFERRAL

Explain:

Conferences (dates) and efforts made to resolve problem(s):

Referral and/or contact with other personnel (school counselor, school nurse, school psychologist, private agencies, SRS, courts, clergy, etc.)

Parent's attitude toward this referral:

PARENT CONSENT FORM - ESC-301

HOME/SCHOOL COORDINATOR

I have received a copy of my parental rights, understand them, and hereby give consent for the Home/School Coordinator to see me and my child.

(Parent/Lawful Custodian)

(Date)

(Teacher's Signature)

(Date)

(Social Worker's Signature)

(Date)

(Principal's Signature)

(Date)

_____ Please check here if your child has previously been referred for Home/School Coordinator/School Social Work Services within the Sedgwick County Cooperative.