



**Referral for Student Health Program
Mental Health**

To be completed by parent(s) or guardian(s)

Name of Child: _____ Date completed: _____

Date of Birth: _____ Personal Health Care Number _____
day/month/year

Telephone: Home: _____ Work: _____ Cell: _____

Address _____

Home/School-related problems: Please describe concerns, behaviors, needs, and any other information that you believe will be helpful to us in working with your child.

Has your child received extra support or counseling in the past? Please describe.

What kind of help would you like for your child and/or your family in solving these problems?

What would you like to see happen for your child?

Signature: _____