(rev 8/2011)

[FOR OFFICE USE ONLY: CASE# SLS__________]

St. Louis County Children's Service Grant

Request Form for School-Based *COUNSELING SERVICES*

Catholic Family Services-School Partnership Program 9200 Watson Road, G101, St. Louis, MO 63126

Office - 314-544-3800 Director – 314-602-6846 Fax - 314-843-0552

DATE OF REFERRAL ______________

STUDENT NAME [one student/referral] LAST ______________________ FIRST ______________________

ADDRESS ______________________ CITY ______________________ ZIP CODE ______________

DOB ____________ GRADE ____________ GENDER __________ RACE __________ HOME PHONE ______________________

PARENT/GUARDIAN NAME ______________________________ WORK PHONE ______________________

PARENT CELL NUMBER ______________________ PARENT E-MAIL ADDRESS (IF APPLICABLE) ______________________

PREFERRED CONTACT TIME[S] ______________________ WHO HAS LEGAL CUSTODY, IF DIVORCED ______________________

DOES THE STUDENT HAVE A CURRENT/PAST IEP? ______________ IS THE STUDENT CURRENTLY TAKING MEDICATION? ______________

DOES THE STUDENT HAVE A KNOWN DIAGNOSIS? ______________________

SCHOOL ______________________ SCHOOL PHONE NUMBER ______________________

SCHOOL ADDRESS ____

PRINCIPAL/PERSON REFERRING ______________________________

TEACHER NAME ______________________ TEACHER E-MAIL ADDRESS ______________________

IS THERAPY A CONDITION FOR STUDENT TO REMAIN IN SCHOOL? YES NO (IF YES, PLEASE GIVE FURTHER EXPLANATION IN COMMENT SECTION BELOW)

ADDITIONAL COMMENTS OR CONCERNS YOU HAVE IN REFERRING THE ABOVE STUDENT (PLEASE ATTACH ADDITIONAL PAGE, IF NECESSARY)

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PLEASE HAVE A PARENT OR TEACHER COMPLETE THE PEDIATRIC SYMPTOM CHECKLIST FOUND ON THE REVERSE SIDE BEFORE SENDING REQUEST FORM