****

**REFERRAL FOR LIAISON FOR STUDENTS WITH HEALTH NEEDS**

**Student Information *(Please complete all sections or referral will be returned for completion)***

|  |
| --- |
| Student’s Name:       Birth Date (m/d/y):       [ ]  M [ ]  FParent/Guardian(s):       Phone: (H)       (W)      Student’s Mailing Address:      (Please include Postal Code)Student’s Civic Address:       |

**School Information**

|  |
| --- |
| School:      Grade:       Phone:      Person Making Referral:       Fax:      Diagnosis (if known) and reason for request (please be specific):        |

**This Section Must Be Completed by Parent/Guardian**

|  |
| --- |
| Additional Comments/Information:   Family Physician: Other Involved Health Providers:  |

**Parent/Guardian Permission:**

I do hereby consent to the referral of my child for assessment and subsequent intervention deemed appropriate by the above professional(s) indicated. I agree that all relevant therapeutic information, including assessments, regular progress reports and audiovisual documentation may be exchanged among any professionals involved in the school, the Regional School Board, South Shore Heath, and other health professionals or external agencies, if deemed necessary. I understand I will be advised of any assessment results and/or planned or ongoing intervention regarding my child, and that I may ask for and receive regular updates.

**Parent/Guardian Signature:** **Date:**

**Teacher’s Signature: Date:**

**Principal’s Signature: Date:**

[ ]  Approved by Principal

Date Referral Forwarded: Date Received: