Yukon
Education

CONSENT FOR REFERRAL TO STUDENT SUPPORT SERVICES

Date: _____

FORM PROCEDURES:

1. School Administrator e-mails form to: mailto:studentsupportservices@gov.yk.ca
2. File a copy in student's cumulative file.

FOR COMPLETION BY STUDENT SUPPORT SERVICES STAFF

Date received: _____ Directed to: _____

Name of Student:	_____ (Surname)	_____ (Given)	
Date of Birth:	_____ (yyyy-mm-dd)	**Grade:**	
School:		**Principal:**	
Teacher(s):		**Case Manager:**	
Name of Parent/Guardian:	_____	**Preferrred phone contact:**	Email:
Relationship:	_____	_____	_____
Name of Parent/Guardian:	_____	**Preferrred phone contact:**	Email:
Relationship:	_____	_____	_____
Language(s) spoken at home:	_____	**First language:**	_____

REFERRAL FOCUS: WHAT IS THE PRIMARY CONCERN REQUIRING SUPPORT FOR THIS STUDENT?

_____

_____

_____

NAME OF STUDENT: _____

☐ Pre-referral consultation completed for requested services

SERVICE REQUESTED FOR (CHECK ONE ONLY):

☐ Student Support Services Consultant
☐ Educational Psychology
☐ Hearing
☐ Occupational Therapy
☐ Speech Language Pathology
☐ Physical Therapy
☐ Vision
☐ Special Education Assistive Technology (SEAT) Services

Is this a reassessment? ☐ Yes ☐ No

CHECK (☐) TO CONFIRM OTHER PROFESSIONAL INVOLVEMENT

☐ Student Support Services Consultant
☐ Educational Psychologist
☐ Hearing Specialist
☐ Occupational Therapist
☐ Physiotherapist
☐ Speech-Language Pathology
☐ Vision Specialist
☐ Medical
☐ Special Education Assistive Technology (SEAT) Services
☐ Other Services _____

Are you the legal guardian of this student? ☐ Yes ☐ No

☐ I/we **CONSENT** for the above named student to receive support services as indicated above.

☐ I/we **DO NOT CONSENT** for the above named student to receive support services as indicated above.

Signature of Parent/Legal Guardian _____

Date: _____

Please note: Your child will be seen by Student Support Services staff on a priority basis determined by the referring school and Student Support Services not necessarily in order of the referral. You will be contacted by the specialist indicated above prior to initiation of service.

Signature of School Administrator _____ Date _____

This information is being collected under the authority of the *Education Act* for the purpose of assessing student needs and determining student programming. This information may be shared with other agencies as required to be in establishing related data bases. This information is protected under the *Access to Information and Protection of Privacy Act*. For further information, please direct inquires to the Principal of the school designated on this form or the Director Student Support Services, at 667-8000.

Print Clear