

Request for School Health Support Services

STUDENT INFORMATION

Student Given Name: _____ Sex: M
Surname: _____ F

Date of Birth (d/m/y): _____ Health Card #: _____ VC: _____

Parent/Guardian Name(s): _____

Cell/Business Phone #'s: Mother: _____ Father: _____

Permission to contact Mother at work: Y N Permission to contact Father at work: Y N

Parent/Guardian informed consent received: Y N Date (d/m/y): _____

Mailing Address (911/Box#): _____

City: _____ PC: _____ Ph: _____

CAS/Homeshare/Other Contact: _____

Referral Initiated by: _____ Relationship: _____

Telephone #: _____ Date (d/m/y): _____

Physician Information: Family: _____ Specialist: _____

Known Diagnosis: _____

SCHOOL INFORMATION

School: _____ Phone: _____ Grade: _____

Attendance: Morning Afternoon All Day Alternate Days

Principal: _____ Teacher: _____

Resource Person: _____

REFERRAL INFORMATION

Assessment requested: OT* PT* Speech* Nursing Nutrition

**all referrals must be accompanied by an appropriate screening tool*

NOTE: shaded sections for CCAC use only – not to be completed by AMDSB staff

