STUDENT SUPPORT TEAM (SST) REFERRAL
Parent/Guardian Form

Student Name	Grade	Date of Birth

Contact Information

Parent/Guardian Name		Teacher(s)
Parent Phone Numbers	Language Spoken at Home	

My Concerns *(In your own words describe what help your student needs.)*

What would you like your child to be able to do? (Describe)

Where does the problem occur? (*Check all that apply***)**

□ Classroom	□ Hallway	□ School grounds	□ Cafeteria
□ Gym	□ Bus	□ Home	
□ Other (describe)			

What has been done so far to help your child?

Medications	Other Relevant Health Information

My Child's Strengths

□ Positive attitude	□ Finishes what he/she starts	□ Handles conflict well
□ Hard worker	□ Organized	□ Athletic
□ Trustworthy	□ Good sense of humor	□ Takes pride in appearance
□ Works well in groups	□ Cooperates	□ Musically talented
□ Works well by him/herself	□ Responsible	□ Artistically inclined
□ Respectful	□ Creative	□ Other
□ Motivated	□ Possesses leadership qualities	

Concerns about How My Child Behaves (*Check all that apply***)**

□ Physically hurts others	□ Easily distracted	□ Gives up easily
□ Is bullied	□ Shy/ withdrawn	□ Is late or skips school
□ Bullies others	□ Gets mad easily	□ Annoys people
□ Destroys property	□ Argues	□ Avoided by peers
□ Says mean things (e.g. makes threats, insults)	□ Is sexually inappropriate (e.g. shows private body parts to others or touches others)	□ Other:

Personal Concerns (*Check all that apply***)**

□ Nervous	□ Poor eyesight	□ Hurts him/herself
□ Sick often	□ Poor hearing	□ Bloodshot eyes
□ Sleeps more than normal	□ Difficulty moving	□ Suspect substance abuse issues (drugs, alcohol, tobacco)
□ Nausea/vomiting	□ Uncoordinated movements	□ Other:

Other Comments/Concerns

Attach any additional information you think might be helpful in understanding your student's needs.

For SST Team:

☐ Request More Information from _____ ☐ Other:

☐ Request Data/Stakeholder Input

☐ Schedule SST Meeting for: _____