DUVAL COUNTY PUBLIC SCHOOLS

Full Service Schools of Jacksonville

Full Service Schools Program
Referral for Services

Date: _____

Student Name: _____ Student Number: _____ School: _____

Grade Level: _____ Age: _____ D.O.B.: _____ Gender: _____ Race/Ethnicity: _____

Address: _____Zip Code_____

Classroom/Homeroom Teacher: _____ ESE Designation: _____

For School Use Only: Caregiver must be notified and consent to referral prior to student being referred for services**

Caregiver Notified of Referral o Yes o No Caregiver Provided Consent for Referral o Yes o No

Consenting Caregiver's Name:_____ Date of Consent for Referral:_____

Please mark the following area(s) of concern and service need:

Classroom Conduct:
- ○ Disruptive
- ○ Defiant
- ○ Skipping
- ○ Inappropriate Responses
- ○ Excessive Absenteeism
- ○ Sleeping in Class

Behavior(s) Observed:
- ○ Negative attitude
- ○ Mood swings
- ○ Withdrawn (loner)
- ○ Extreme weight loss/gain
- ○ Anger
- ○ Physical aggression
- ○ Difficulty accepting mistakes
- ○ Gang/Occult related drawings /symbols and affiliation
- ○ Self-Harm Behaviors
- ○ Suicidal/homicidal thoughts
- ○ Depressed mood (sad)
- ○ Poor Social Skills
- ○ Bullying
- ○ Defensiveness

Academic Performance Observed:
- ○ Declining quality of work
- ○ Lack of motivation
- ○ Lack of concentration/attention focus
- ○ Academic Failure
- ○ Unrealistic expectations

Other/Comments:

_____
_____
_____
_____
_____
_____

Is the student receiving services from another agency? ○Yes ○No
If yes, list agencies and contact names (if known):

_____
_____

For School Use Only:
Has the student been referred to the Threat Assessment Team? ○Yes ○No

Personal/Family/Friends Issues:
- ○ Divorce/Separation
- ○ Grief/Loss
- ○ Abuse/Neglect
- ○ Recently moved to the area
- ○ Sexual identity/orientation (Struggles/Self Referrals)
- ○ Poor Relationships
- ○ Negative Influences
- ○ Low Self-Esteem

Possible Alcohol/Drug Usage:
- ○ Suspected use, possession, distribution, or sale of tobacco, alcohol, or other drugs

Health and Wellness Services Need:
- ○ Individual Counseling ○ Group Counseling
- ○ Medical ○ Clothing ○ Mentoring
- ○ Food ○ Vision ○ Teen Parent Services

_____

Parent/Guardian:_____

Relationship to student: _____

Telephone: _____

Email Address: _____

_____

○ Self-Referral by Parent/Guardian

○ Self-Referral by Student

○ Referred by Other

Name: _____

Title/Position:_____

Telephone: _____Fax: _____

Email Address: _____
