DUVAL COUNTY PUBLIC SCHOOLS

Full Service Schools Program
Referral for Services

Full Service Schools OF JACKSONVILLE

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: ○Yes ○No Caregiver Provided Consent for Referral: ○Yes ○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○Withdrawn (loner)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
○Self-Harm Behaviors
○Suicidal/homicidal thoughts
○Depressed mood (sad)
○Poor Social Skills
○Bullying
○Defensiveness
○Gang/Occult-related drawings/symbols and affiliation

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
○Medical
○Food
○Clothing
○Vision
○Group Counseling
○Mentoring
○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: _____