MASTER'S
ACADEMY & COLLEGE

Family School Liaison Counseling Referral Form

Master's Academy & College and Palliser Regional Division No. 26

Student Name: _____ **Date Referred:** _____

Age: _____ Birthdate: _____ Referred by: _____

Grade: _____ Homeroom Teacher: _____

Mother Name: _____ Phone: _____ Lives with: ☐ Mail to: ☐

Email: _____

Father Name: _____ Phone: _____ Lives with: ☐ Mail to: ☐

Email: _____

Custody: _____ Obtained verbal parental consent: ☐

Full Mailing Address: _____

_____

_____

STUDENT CONCERNS: Please indicate appropriate descriptors

☐ Abusing Others	☐ Dating Relationship	☐ Friendship problems	☐ Obsessions	☐ Social skills
☐ Academic Concerns	☐ Decision-making	☐ Low self-esteem	☐ Physical Abuse	☐ Stress
☐ Lack of Ambition	☐ Depression	☐ Lack of energy	☐ Physical Ailments	☐ Substance abuse
☐ Anxiety	☐ Divorce/separation	☐ Loneliness	☐ Poor concentration	☐ Suicidal thoughts
☐ Anger/Acting Out	☐ Drug/alcohol abuse	☐ Looks/acts tired	☐ Sadness	☐ Work habits
☐ Attendance	☐ Eating disorders	☐ Loss/grief	☐ Self-control	
☐ Attention Problems	☐ Emotional abuse	☐ Memory problems	☐ Self-harm	
☐ Bullied by others	☐ Family Concerns	☐ Nervous/irritable	☐ Sexual concerns	
☐ Bullying others	☐ Fears	☐ Nightmares	☐ Sleep/insomnia	

Additional information or concerns (if there has been previous involvement by other agencies, etc., please describe/explain):

_____

_____

_____

Teacher's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____