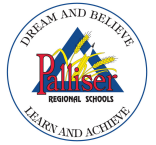




MASTER'S
ACADEMY & COLLEGE



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

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