



# Parent or Guardian Referral Form

Office of Instruction  
Mat-Su Borough School District

Date:

Name of child:  Your name:

Relationship to child:

The school's care team may wish to contact you to discuss your referral concerns. Please provide your contact information and best time to reach you.

Phone:  Best time to contact:

Who does your child live with?

Biological parents  Relative

Adoptive parents  Group home

Foster parents  Other:

Desired Language of Service:

Does your child have an individualized education plan (IEP)?

Areas of concern:

Academic concerns  Emotional concerns

Behavioral concerns  Physical Health concerns

Social concerns  Family concerns

Other:

Behavioral concerns (please mark all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Exposed to community violence, other trauma | <input type="checkbox"/> Sad, depressed or irritable mood          |
| <input type="checkbox"/> Nightmares, intrusive thoughts              | <input type="checkbox"/> Hopelessness, negative view of future     |
| <input type="checkbox"/> Anxious, fearful or irritable mood          | <input type="checkbox"/> Low self-esteem, negative self-statements |
| <input type="checkbox"/> Jumpy or easily startled                    | <input type="checkbox"/> Difficulty concentrating                  |
| <input type="checkbox"/> Avoids reminders of trauma                  | <input type="checkbox"/> Diminished interest in activities         |
| <input type="checkbox"/> Sexualized play or behaviors                | <input type="checkbox"/> Low or decreased motivation               |
| <input type="checkbox"/> Talks excessively                           | <input type="checkbox"/> Difficulty sleeping                       |
| <input type="checkbox"/> Gets out of seat and moves constantly       | <input type="checkbox"/> Worries excessively                       |
| <input type="checkbox"/> Interrupts and blurts out responses         | <input type="checkbox"/> Restless and on edge                      |
| <input type="checkbox"/> Inattentive, distractible, forgetful        | <input type="checkbox"/> Specific fears or phobias                 |
| <input type="checkbox"/> Disorganized, makes careless mistakes       | <input type="checkbox"/> Clingy behavior                           |
| <input type="checkbox"/> Angry towards others, blames others         | <input type="checkbox"/> Fights and is aggressive                  |
| <input type="checkbox"/> Argumentative and defiant                   |  |

How often has this behavior been occurring? (e.g. several times per day; 1-2 times per week)

How long have you had this concern about your child? (e.g. several weeks, several months)

To your knowledge, has your child ever received any supports or interventions for this behavior in the past?

To your knowledge, is your child receiving any supports or interventions for this behavior currently?

What do you think will help your child experience success?