Taylor County School District, Florida
Mental Health Services
REFERRAL FORM

Student:_____ **Referral Date:**_____

School: _____**Referred by:**_____

DOB:_____ **Grade:**_____

Address:_____ **City/State:**_____**Zip:**_____

INSURANCE / SOCIAL SECURITY INFORMATION RELEASE

Parent/Guardian Name:_____

Cell Phone#:_____ **Alt. #:**_____

Primary Insurance:_____ **ID#**_____

Student SS#:_____

I,_____ (Printed Parent Name) have read the Parent Permission Form and agree to allow my child _____ (Printed Child's Name) to attend and participate in counseling in the Taylor Counseling school program.

Parent/Guardian Signature:_____Date:_____

Reason for Referral/concerns:

Date	Action Taken and Results	Initials

Date:_____ **Signature:**_____
Mental Health Coordinator/ Designee

File Copy ☐
Referral Source copy sent:_____ by _____