

THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA
REQUEST FOR GUIDANCE SERVICES

Send form to Guidance and Counselor will contact student.

Date: _____ Student Name: _____

Grade/Major: _____ ID # _____ Period _____

CHECK (✓) REASON(S) FOR REFERRING

Academic		Discipline		Personal Problem		Student/Teacher Relationship	
<input type="checkbox"/>	Subject too easy	<input type="checkbox"/>	Unwilling to do work	<input type="checkbox"/>	Poor Attendance	<input type="checkbox"/>	Poor Attitude
<input type="checkbox"/>	Subject too hard	<input type="checkbox"/>	Does not bring materials	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Cannot follow directions	<input type="checkbox"/>	Disrupts class	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Lacks motivation	<input type="checkbox"/>	Other:	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Other:	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

Have you talked to the student or parent; if so what transpired?

What other actions have you taken?

What would you like to see happen for this student?

Any other information you would like to share.

Person making referral (Print & Sign) _____

Date _____

GUIDANCE REPLY	
<input type="checkbox"/>	Conference with student
<input type="checkbox"/>	Conference with / call to parent
<input type="checkbox"/>	Referral to outside agency
<input type="checkbox"/>	Student Contract
<input type="checkbox"/>	Will meet with student individually or in group setting
<input type="checkbox"/>	See me at your convenience
<input type="checkbox"/>	In-house referral (Please see them for the follow up)

Signature of Counselor _____

Date _____