



**DISTRICT SCHOOL BOARD OF PASCO COUNTY
YOUTH AND FAMILY ALTERNATIVES TRUANCY REFERRAL FORM**

MIS Form #402
Rev. 4/11

7524 Plathe Road
New Port Richey, FL 34653
727-835-4166

**TRUANCY
REFERRAL**

**UNGOVERNABLE
REFERRAL**

38022 River Road
Dade City, FL 33525
352-523-5020

Name of Parent(s) or Legal Guardian(s) _____

Name of Child _____ DOB _____ Sex _____ Race _____

Address _____

Telephone (H) _____ (W) _____ (C) _____

School _____ Grade _____ Student # _____

Brief explanation of presenting problem: _____

List other agency referrals/involvement: *Do not refer if involvement with DCF or DJJ* _____

Does the student currently have an Individualized Education Plan (IEP)? Yes _____ No _____

If yes, please indicate the ESE program _____

1. Parent contacted to determine the reason for each unexcused absence. Date _____

Responsible Party _____

2. School representative sent a registered letter to the home, explaining Florida Law. Date _____

Responsible Party _____

3. Home visit attempted and/or any other attempted contact with parent and/or child. Date _____

Responsible Party _____

4. School Based Intervention Team (SBIT) was held. Recommendations made: Date _____

***Date Parent or Guardian notified** _____ ***Method of notification** _____

a) _____

b) _____

c) _____

d) _____

AUTHORIZATION FOR EXCHANGE OF INFORMATION/RELEASE OF CLIENT RECORDS

Permission is hereby given to Youth and Family Alternatives and the District School Board of Pasco County to release/exchange information including medical, psychiatric, psychological, social/developmental, substance abuse, intake and discharge summaries, progress notes, and treatment plans regarding the above named child. This release shall be in compliance with Federal regulations (42 CFR Part 2, Section 3 of Public Law 91-616, as amended by public Law 93-282) and with all applicable state laws, local laws, and regulations. Information released may not be redisclosed without further authorization by the client/representative.

The client/representative has been given the opportunity to discuss the possible benefits and disadvantages of releasing the information. This authorization is freely and voluntarily given, and provision of the services is not dependent upon the client/representatives decision regarding release. This authorization shall be terminated one year from the date of signature unless otherwise specified. This consent may be revoked by the client/representative at any time. Revocation has no effect on action previously taken.

Parent *(If parent is unavailable, please document attempt(s) to have parent sign)*

School Social Worker

Date