

EXHIBIT A

TRANSITIONAL SERVICES FOR YOUTH & FAMILIES
STUDENT INFORMATION PROFILE

Date: _____

Student & Family Information

This Agreement is made with reference to services to be performed for:

_____ Social Security # _____
Name of student

DOB: _____ Grade: _____

Address of student: _____

Telephone: (____) _____

_____ _____
Name(s) of parent(s) or guardian(s)

Custodial parent or guardian

Parent or Guardian address (if different than student)

(____) _____ (____) _____
Parent or Guardian phone (day) Parent or Guardian phone (cell/evening)

Parent or Guardian email

School Information

Name of School: _____

School telephone number: (____) _____

Primary school contact: _____

Special Education Director: _____

Special Education Director phone #: (____) _____

Special Education Director email: _____

Special Education Case Manager: _____

Special Education Case Manager phone #: (____) _____

Special Education Case Manager email: _____

Reason for referral:

Relevant diagnoses and medical/psychological/learning needs:

Restrictions on student:

Primary Physician's name and phone number: _____

Medical/Health Insurance Provider: _____

Emergency contact name and phone number: _____

Signature of Authorized School Administrator

Name: _____

Title: _____