Parent INITIATED REFERRAL FORM for SAP

Date: ________________ Person making referral (Optional)_____________________________________

I want to refer (Name of Student) ________________________________ to the Student Assistance Program (SAP) for help.

The reason I am referring them is:

_____ Uses drugs or alcohol

_____Threatens to run away

_____ Extreme sadness

_____ Threatens to hurt self or other

_____Cannot sleep

_____Has eating problems

_____Seems seriously worried

_____ Self-harm

_____Always angry or crying

_____Uses Steroids

_____Other (write in reason)____

____

This information will remain confidential. Please place in a sealed envelope, label it SAP and return it to ACCHS.

If this issue/concern requires immediate attention please contact the School Counseling Office at

610-437-4601 extension 110.