ACADEMIC SUPPORT REFERRAL

Student Information

Student Name: _____ Grade: _____

School:_____ OVUMS _____ Lothrop _____ Whiting
_____ Leicester _____ Neshobe _____ Other

Classroom Teacher: _____

Referral Made By:

_____ Classroom Teacher _____ Educational Support Team _____ Other

School Contact Person: _____ Telephone: _____

Referral made for the following academic supports: _____ Reading _____ Mathematics

Parent Contacted On: _____

Parent/Guardian Permission for Academic Support During After School

Parent Name: _____

Address: _____

Home Phone:_____ Work Phone:_____

I, _____, give permission for my child _____

to receive individualized academic support from a teacher contracted by SOAR After School Program for this purpose. I understand this support does not provide specialized instruction and does not replace other tutoring my child's school may be required to provide.

Return Form To: _____ Session # : _____

Date Received by ASP Coordinator: _____ Date Received by Tutor: _____