TOWN OF STRATFORD

Birdseye Municipal Complex, 468 Birdseye Street, Stratford, CT 06615
Phone: 203-385-4095 • Fax: 203-381-2064
www.townofstratford.com

COMMUNITY SERVICES

STRATFORD JUVENILE REVIEW BOARD

School Referral Form

Please fill in as much information as possible.

Youth Name:_____ DOB:_____

Youth Address:_____.Zip Code: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Contact Number(s): _____

School Name:_____ Referral Date:_____

Referral Contact:_____ Contact Number:_____

Reason(s) for Referral:

Referral Behavior and Incident Details (including interventions/efforts made):

Parent/Legal Guardian Involvement:

Was the school impacted by this behavior? Yes_____ No_____

What does the school need from this youth to make things right?

Current Academic Functioning:

____Current Grade _____ Credits Earned (to date) _____Current GPA

IEP? __ Yes ____No 504 Plan? ____Yes ____ No

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COMMUNITY SERVICES

Youth and Parent/Guardian Consent to Release Information and Referral to Stratford JRB

Notice, Waiver of Rights and Consent to Release Information

Youth: I would like my case diverted to the Stratford Juvenile Review Board (JRB). I have been advised of my right to confidentiality regarding my juvenile arrest, court record and history. I hereby waive this right and consent to have the Police Department and Juvenile Court provide information to the Stratford Juvenile Review Board to determine eligibility for my case. If my case is eligible, I agree to work with the JRB to develop an appropriate reparative action plan to resolve this matter.

I give consent for the Stratford Community Services, working on behalf of Stratford Juvenile Review Board, to obtain information from school personnel regarding my academic and behavioral history. I give consent to Stratford Community Services to speak to any school personnel who may help with the progress of my case.

Parent/Legal Guardian: I (We) agree and consent to the terms and conditions of the above Notice, Waiver and Release of Information. I (We) authorize information regarding this case be provided to the Stratford Juvenile Review Board. I (we) agree to work with my/our child and the JRB to develop an appropriate reparative action plan to resolve this matter.

This authorization expires in one (1) year unless expressly revoked earlier or case is closed.

_____ _____
Youth Signature Date

_____ _____
Parent/Legal Guardian's Signature Date

_____ _____
Parent/Legal Guardian's Signature Date

_____ _____
School Staff/ Witness Signature Date

Referral Source Authorization:

Printed Name: _____

Signature: _____

Date: _____

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COMMUNITY SERVICES

PLEASE SEND SIGNED REFERRAL & AUTHORIZATION TO STRATFORD JRB:

MAIL	FAX
Stratford Community Services 468 Birdseye Street Stratford, CT 06615	Fax: 203-381-2064 E-mail: pmorrisroe@townofstratford.com
Attention: Paige Morrisroe, LMFT, Clinical Coordinator	

Please call Community Services at (203) 385-4095 to confirm receipt of faxed referral. Once all information is received, the family will be contacted to begin JRB intake process.

**NOTES TO SCHOOL:

- KEEP COPY OF REFERRAL IN STUDENT FILE
- SUPERINTENDENT SIGNATURE IS NOT REQUIRED FOR REFERRAL SUBMISSION; PRINICIPAL SIGNATURE ONLY REQUIRED.
- SUPERINTENDENT DOES REQUEST REFERRAL UPDATES AS NEEDED FROM THE SCHOOL. JRB DOES NOT UPDATE SUPERINTENDENT.