WESTWIND SCHOOL DIVISION #74
Box 10 445 Main Street Cardston AB T0K 0K0 ph: 403 653 4991 fax: 403 653 4641
"empowering potential"

Box 10, Cardston, Alberta T0K 0K0
Ph: (403) 653-4991 Toll Free: 1-800-655-4991 Fax: (403) 653-4641

STUDENT ASSESSMENT REFERRAL FORM

1. **STUDENT INFORMATION:**

Student Name: _____ **D.O.B.** _____/_____/_____
Year Month Day

Parent(s)/Guardian(s): _____

Address: _____ **Phone: (Res)** _____ **(Bus)** _____

School Name: _____ **Grade:** _____ **Date of Referral:** _____

Teacher: _____ **Referring Person/Agency:** _____

2. **PURPOSE OF REFERRAL:**

_____

_____

_____

_____

_____

_____
Signature of Principal

2. **To assist us in planning an adequate educational program for your child, we request your permission to administer individual diagnostic tests to your child (intellectual, psycho-educational, behavioral, achievement, etc.). Please note that assessment results are confidential and are shared only with the parent(s)/guardian(s) and those persons involved in the planning and providing of educational programs for your child. If you have any questions please contact the school at _____.**

As the parent(s) or legal guardian(s) of _____, I hereby authorize an individual assessment of my child to be completed by Westwind School Division No. 74 and agree that these results can be shared with school personnel involved in planning and providing educational programs for my child.

_____ _____
Signatures of Parent(s) or Guardian(s) **Date**

The above statement of consent for assessment will be valid for a period of 120 school days following the date of this document. I understand that for this school year Mr. Conrad Boehme, Provisional Psychologist, will be providing psycho-educational services for the Westwind School Division No. 74 under the supervision of Dr. Bev Muendell-Atherstone, Chartered Psychologist #844, as authorized by Dr. Neldon Hatch, Assistant Superintendent of Westwind School Division #74 and the College of Alberta Psychologists.

TO BE COMPLETED PRIOR TO SUBMITTING TO CENTRAL OFFICE

Student Name: _____ **School:** _____

1. Details of referral:

2. Results of previous testing (i.e. group or individual/CCAT, Alberta Achievement Tests, informal tests, etc.)