

**VALLEY VIEW LEARNING CENTER**

Referring School: \_\_\_\_\_ Date of Referral: \_\_\_\_\_  
Student: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_  
Student entered 9<sup>th</sup> grade in year: \_\_\_\_\_ MARSS#: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Student receives (circle one): **regular-price lunch** **reduced-price lunch** **free lunch**

The following applies to this student (check all that apply):

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | Poor attendance record (frequent absence, tardiness and/or truancy)   |
| <input type="checkbox"/> | Is at least one grade level below the performance level for students of the same age as measured in a locally determined achievement test |
| <input type="checkbox"/> | Is recognized by school personnel to be experiencing academic or personal difficulties  |
| <input type="checkbox"/> | Is a pregnant or parenting teen   |
| <input type="checkbox"/> | Has formally dropped out and returned to school   |
| <input type="checkbox"/> | Is enrolled in a public alternative school  |
| <input type="checkbox"/> | Has been assessed as chemically dependent   |
| <input type="checkbox"/> | Is a juvenile offender/diversion program youth  |
| <input type="checkbox"/> | Is homeless or has experienced homelessness (as defined by Stewart B. McKinney Homeless Assistance Act)                                   |
| <input type="checkbox"/> | Is limited in English proficiency   |
| <input type="checkbox"/> | Is a youth with a disability. Specify disability: _____   |
| <input type="checkbox"/> | Is a victim of physical or sexual abuse   |
| <input type="checkbox"/> | Has experienced mental health problems.   |

Please list subject, grade and credits needed for this student (example: English 9 -- .5 credits):

Course	Grade Level	Credit needed

Necessary records attached:  **Health/Immunization**  **Transcripts**  
 **Standardized Test Results**  **IEP/504**

**Signature of Referring Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*Districts referring a student with an IEP must hold a change of placement meeting prior to the student attending the alternative learning center. Students will be contacted once all information is received.

**STUDENT INFORMATION:**

Who does student live with (circle one): **Mom Dad Both Mom & Dad Other:**\_\_\_\_\_

Address of non-custodial parent (if you wish to receive duplicate mailings of student information):

\_\_\_\_\_

How will student get to school: \_\_\_ Bus \_\_\_ Private Transportation \_\_\_ Walk

Emergency Contact Name and Phone Number: \_\_\_\_\_

Doctor/Medical Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

Any allergies or chronic health problems: \_\_\_ Yes \_\_\_ No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Is student currently taking any prescription medications? \_\_\_ Yes \_\_\_ No If yes, please specify:\_\_\_

\_\_\_\_\_

(Students must bring any medications that are to be taken during school hours in a prescription and/or original bottle marked with student's name to the school office. School staff will store medications and administer medications according to prescription/directions)

Is student presently working? \_\_\_\_\_ If yes, where? \_\_\_\_\_

How many hours per week? \_\_\_\_\_ Work phone number: \_\_\_\_\_

**Complete This Section Only If Student Returning to School After Dropping Out:**

Last School Attended: \_\_\_\_\_ Date Last Attended: \_\_\_\_\_

What grade was student in when he/she last attended school? \_\_\_\_\_

Number of high school credits student has earned (if known): \_\_\_\_\_

Did student receive any of the following kinds of special help in school:

Basic Skills: Yes \_\_\_\_\_ No \_\_\_\_\_

Reading: Yes \_\_\_\_\_ No \_\_\_\_\_

IEP/Special Ed. Yes \_\_\_\_\_ No \_\_\_\_\_

Why does student wish to return to school? \_\_\_\_\_

\_\_\_\_\_