

# Self Referral Form

## For SCUSD Teen Parent Program

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Print this form. Please fill out completely.  
If you have any questions, please call (916) 277-6767

**Fax to 277-6850**

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Today's Date: \_\_\_\_\_

Agency/ School/Person  
Referring Services: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Student Name: \_\_\_\_\_

Student DOB: \_\_\_\_\_

School / Grade Level: \_\_\_\_\_

Primary Language: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

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

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### Emergency Crisis Assistance

- Food
- Clothing
- Shelter
- Utilities
- Transportation
- Baby Supplies

### Family Support

- Child Discipline
- Counseling
- Stress Management
- Domestic Violence
- Drug & Alcohol Abuse / Treatment
- Health Needs (medical, dental, nutritional, health insurance)
- Legal Issues
- Special Needs
- Child Care

### Education/Employment Training

- GED/HS Diploma
- College
- ESL
- Vocational Training
- Money Management
- Improved Reading/Writing