

**Flagstaff Unified School District
Counseling Office Request For Student Education Assistance**

Name of person making the request: _____ Relationship to student: _____

Date this form is being submitted to the Counseling Office: _____

Name of student in need: _____ Grade: _____ School: _____

Indicate the Area(s) of Concern: Academic Social-Behavioral Emotional Health Attendance

Write a brief description of any concerns indicated above:

Teachers: Attempts to contact the student’s caregivers and notify them of any concerns are required prior to completion of this form. Please indicate your contact attempts and results in the following table.

DATE	TEACHER’S NAME	RESULTS OF CONTACT (e.g., left voicemail, parent-teacher conference, discussed concerns with parent over the phone, parent concerned, parent not concerned).

Return the completed form to the student’s assigned school counselor. The school counselor will follow-up with you regarding recommendations for which step will be taken next.

TO BE COMPLETED BY THE SCHOOL COUNSELOR

REVIEWED BY (school counselor): _____ on _____ (date).

PRELIMINARY RESOLUTION(S)

- Professional conference Parent-teacher conference Referral to Student Success Team
- Request for additional documentation (e.g., medical, school, or mental health records)
- Other: _____

Note: Parents must be notified of any verified educational concerns within 10 school days.