CAPITAL REGION BOCES
Special Education Division
900 Watervilet-Shaker Road
Albany, NY 12205
(518)464-6300
FAX (518)464-6301

Student Referral Form

Referral for: Academic Year _____ ☐ESY ☐ RSY

Student Information

Last Name:_____ First Name:_____ MI:_____

Date of Birth: ____ / ____ /_____ Gender: ☐Female ☐Male Anticipated Enrollment Date:_____ /_____ /_____

Race (Check all that apply) : ☐ American Indian/Alaskan Native ☐ Asian ☐Black ☐Native Hawaiian/Other Pacific Islander ☐ White

Is this student Hispanic, Latino or of Spanish origin? ☐Yes ☐No

Home District:_____ Home School:_____

Home School ID: _____ STAC ID: _____

Current Grade:_____ 9th Grade Date of Entry (Cohort):_____

NOTE: The following question is optional. We ask it to help prevent the creation of duplicate records in our student management systems.

Has this student or their relative ever attended a Capital Region BOCES program (CTE, Special Education, etc.)? ☐Yes ☐No
Relative Name_____

Household Information

Household Address: _____

City:_____ State:_____ Zip:_____

Mailing Address: _____

City:_____ State:_____ Zip:_____

Guardian Name:_____

Relationship to student:_____

Custodial Parent? ☐Yes ☐No

Resides in Household? ☐Yes ☐No*

Receive correspondence? ☐Yes ☐No

Daytime Phone: (_____)_____-_____x_____

Evening Phone: (_____)_____-_____x_____

Email Address:_____

***If guardian resides at an address that is different than the one above, please indicate their address here:**

Address:_____

City:_____ State:_____ Zip:_____

Guardian Name:_____

Relationship to student:_____

Custodial Parent? ☐Yes ☐No

Resides in Household? ☐Yes ☐No*

Receive correspondence? ☐Yes ☐No

Daytime Phone: (_____)_____-_____x_____

Evening Phone: (_____)_____-_____x_____

Email Address:_____

***If guardian resides at an address that is different than the one above, please indicate their address here:**

Address:_____

City:_____ State:_____ Zip:_____

Referral Request Details

Assessment Type: ☐Regular Assessment ☐NYSAA

Special Alerts: _____

_____

_____

_____

_____

Programs

Grade Level	Center Based Programs	Public School Based Programs
Elementary	☐ Ready to Learn (4:1:2) ☐ Pathway to Learning (6:1:2) ☐ TEACCH (6:1:2) ☐ Developmental Skills NYSAA (6:1:2) ☐ Medically Fragile (8:1:2)	☐ Social Emotional (8:1:2) ☐ Deaf and Hard of Hearing (6:1:2) ☐ Deaf and Hard of Hearing (8:1:2)
Middle School	☐ Ready to Learn (4:1:2) ☐ Pathway to Learning (6:1:2) ☐ Developmental Skills NYSAA (6:1:2)	☐ Developmental Skills NYSAA (6:1:2) ☐ Deaf and Hard of Hearing (8:1:2) ☐ Social Emotional (8:1:2)
High School	☐ Pathway to Learning (6:1:2) ☐ Developmental Skills Life Skills (8:1:2) ☐ Social Emotional (8:1:2) ☐ Medically Fragile (8:1:2) ☐ TEACCH (8:1:2)	☐ Developmental Skills Regular Assessment (12:1:2) ☐ Developmental Skills Functional Skills (12:1:2) ☐ Developmental Skills Functional Skills 18-21 (12:1:3) ☐ Deaf and Hard of Hearing (12:1:2) ☐ Social Emotional (8:1:2)
Specific information on the learner characteristics for each program can be found on the Capital Region BOCES website: https://www.capitalregionboces.org/special-education/program-descriptions/		

Guardian Consent for the Release of Student Records

Have the student's Parents/Guardians been notified of this referral to Capital Region BOCES. (Circle One) **YES NO**

Explain:_____

District Contact

Main Contact (individual making this referral, typically the CSE)

Name:_____ **Title:** _____

Phone: (_____)_____-_____x_____ **Email Address:**_____

Alternate Contact (such as the student's teacher/social worker)

Name:_____ **Title:** _____

Phone: (_____)_____-_____x_____ **Email Address:**_____