SCHOOL DISTRICT REFERRAL
TO
REHABILITATION SERVICES FOR THE BLIND

☐ I do not wish for a referral to be made at this time.

☐ I wish for a referral to be made and I give consent to release the following information to Rehabilitation Services for the Blind:

_____ _____

Date Signature

_____ _____

Student Name Date of Birth

_____ _____

Address City, State, Zipcode

_____ _____

Home Phone Number Work Phone Number (If applicable)

_____ _____

Parent Cell Phone Parent Email Address

Preferred Contact Method: __Home Phone __Cell __Work __Email

_____ _____

Parent/Guardian Name (Please Print) County
(Not required if student is age 18+)

_____

School District Name

_____ _____

School Contact Name (Please Print) Contact Phone Number

_____ _____

School Contact Role Contact Email

Directions: 1. Maintain copy of release in student's record.
2. Send referral to the attention of: Deputy Director
Rehabilitation Services for the Blind
P.O. Box 2320
615 Howerton Court
Jefferson City, MO 65102-2320