

**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/Guardian Name
(Not required if student is age 18+)

County

School District Name

Contact Name

Contact Phone Number

- 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