Minnewaska Area Schools
ENGAGE EVERY STUDENT, EVERY DAY! District 2149

Please complete and return to Minnewaska Mental Health Services staff via email or paper copy:
Kemma Wing – kwing@isd2149.org

Student's Name: _____ Date: _____

Grade: _____ Age: _____ Date of Birth: _____

Parent/Guardian's Name: _____

Home Address: _____

_____

Home Phone: _____ Work Phone: _____

Person Referring: _____ Phone: _____

Parents must be aware this referral is being made. Who initiated the referral? (parents, school staff, county worker) _____

Parents response? _____

Is the student receiving any services with the MAS social worker or school counselor(s)?☐Yes /☐No

Children's Mental Health Case Management Services?☐Yes /☐No

CMH Case Manager: _____ Phone: _____

Is the student currently receiving special education services?☐Yes /☐No

Identify (at least 5) symptoms, behaviors, concerns, and problems that the student has been exhibiting:

_____

_____