Tompkins County Solution Focused CARE Team Meeting Request Form

Please FAX completed form to (607)-274-6316

Person requesting the meeting: _____ Date of request: _____

Your Role (circle one) *school staff* *community provider* *parent/guardian*

Email:_____ Phone:_____

Name of child:_____ Age:_____ School _____

Name of Parent/Caretaker _____

Email: _____ Phone: _____

Name of Parent/Caretaker _____

Email: _____ Phone: _____

Please briefly describe the reason for requesting a CARE Team meeting:

IMPORTANT! Referral must include Page II that includes the parent consent for referral and release of confidential information

Please share the names of people you would like to include in the CARE Team meeting (pending approval of the family).

Name	Role	Email	Phone

Parent Consent for Referral for a CARE Team meeting

and Release of Confidential Information

My child's name _____ Date of Birth _____

I _____ am in support of this referral for a Solution Focused CARE Team meeting. I understand that I will guide who will attend the meeting and where and when the meeting will occur. I give my permission for the CARE team facilitator to communicate with the referral source, the individuals mentioned on the referral form and any others that I indicate should be invited to the meeting. Communication will be limited to the information necessary to set up and facilitate the CARE Team meeting. (No social history, assessments, clinical or educational information will be shared prior to the CARE team meeting.)

_____

Signature of Parent/Guardian *Date*