

**REFERRAL TO SCHOOL SUPPORT TEAM  
FOR  
BEHAVIORAL ASSESSMENT**  
Sevier County Schools

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_  
Parent/Guardian Name \_\_\_\_\_ Date of Referral \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Referring Person \_\_\_\_\_ Position \_\_\_\_\_  
Teacher(s) \_\_\_\_\_  
Special Education Student:  Yes  No If yes, certification \_\_\_\_\_  
Agencies involved (if applicable): \_\_\_\_\_

Referral Behavior(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Frequency of Problem Behavior(s): \_\_\_\_\_

Duration of incident(s): \_\_\_\_\_

Length of time exhibited: \_\_\_\_\_

Interventions that have been or are currently being used (*include positive*): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Team Decision: Functional Behavior Assessment to be done:  Yes Date \_\_\_\_\_

No Reason: \_\_\_\_\_

If yes, obtain parent permission:

Name of Student _____ <input type="checkbox"/> I give permission for school staff to conduct a Functional Behavior Assessment. I understand that I will be an active participant in the process. <input type="checkbox"/> I do not give permission for a Functional Behavior Assessment for the following reason(s): _____  Signed _____ Date _____
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