



WELLNESS CENTER REFERRAL SLIP

Name: _____

Date: _____

Choose One: Student

Parent/Guardian

Teacher/Staff

Part I: Reason(s) for Wellness center referral:

PART II: Services Needed (circle all that apply)

Counseling (Meet with social worker)	Housing Assistance	Clothing
Parenting Class	Haircut/Hair Braiding	Food
Group Therapy	Medical (Vision/Dental)	Academic Tutoring

Best form of contact:

Phone

Email

ClassDojo

Phone: _____

Email: _____

Signature: _____