

## CARE Team Meeting Request Form

*Collaborate*

*Align*

*Respond*

*Engage*

Please scan and email completed form to [sallymcoss@rackercenters.org](mailto:sallymcoss@rackercenters.org) or

FAX form to (607)-274-6316

Attention: Sally Manning

Call Sally at 607-592-0992 with questions.

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  
Parent/guardian 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 and release of confidential information for CARE Team meeting**

My child's name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I \_\_\_\_\_ am in support of this referral for a 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 choose to 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.) I understand that this completed form will either be scanned and emailed or FAXed to the CARE team coordinator upon completion.

\_\_\_\_\_  
*Signature of Parent/Guardian*      *Date*