

**Parent Support Network**  
PO Box 284  
Orangeburg, NY 10962  
(845) 359-6090 fax (845) 359-6248

**HELP/ADVOCACY REQUEST**

**CHILD'S INFORMATION**

Child's name _____ M__ F__ Date of birth _____ Age _____
Parent/Guardian _____
Address _____ City _____ St__ Zip_____
Home phone _____ Work phone _____ Fax _____
Email address _____
Siblings (names & ages) _____

**SCHOOL INFORMATION (Please attach first page of current IEP)**

Current school placement _____ Grade_____
Educational classification _____
Home school district _____ School contact _____
School phone _____ School fax _____

**MEDICAL INFORMATION**

Child's doctor _____ Child's doctor _____
Address _____ Address _____
City _____ St__ Zip _____ City _____ St__ Zip _____
Phone _____ Fax _____ Phone _____ Fax _____
Medical diagnosis _____
Medications _____

ASSESSMENT (please use separate page if necessary)

Child's Strengths

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Child's social communication ability

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Child's peer friendships/relationships

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What issues/behaviors need to be addressed?

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OTHER CONTACT INFORMATION (if applicable)

Case Manager \_\_\_\_\_ Therapist \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

REFERRAL INFORMATION

How did you hear about Parent Support Network?

Friend  Teacher  Workshop  Newspaper  Cable  Internet  Agency listed below

Referred by \_\_\_\_\_ Agency \_\_\_\_\_

Agency phone \_\_\_\_\_ Agency fax \_\_\_\_\_ Date of referral \_\_\_\_\_

RELEASE & AUTHORIZATION

I hereby authorize Parent Support Network, Inc. and its representatives ("PSN") to have ongoing professional communications with, and to obtain copies of educational, medical, psychological and psychiatric records of the above named child from his/her school, other educational sources, doctors, therapists, counselors and all such professionals, who are hereby authorized to release copies of such records to PSN. A copy of this Release & Authorization shall be sufficient as an original. PSN, in its discretion, is authorized to disclose such information and records in its efforts to advocate in the interests of the above-named child. This authorization shall remain in full force and effect until revoked by me in writing and delivered to PSN.

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Mail to Parent Support Network, Inc.  
PO Box 284  
Orangeburg, NY 10962  
or fax to fax: (845) 359-6248

Micki Leader, President  
phone: (845) 359-6090  
e-mail: [info@parentsupportnetwork.org](mailto:info@parentsupportnetwork.org)