THE LITERACY PROJECT
Read Well Speak Well Live Well

Study Friends
Student Referral Information

THIS IS A: (check one or both)

☐ **Study Friends 1-to-1 match referral** ☐ **Algebra Tutorial referral**

Date: _____ School: _____

Student Name: _____

Grade: _____First Language: _____

Birth Date: _____Reading Level (approx.): _____

Physical Address: _____

Mailing Address: _____

Parent/ Guardian A Name: _____

Parent/ Guardian B Name: _____

Home Phone #: _____Cell Phone # (if avail.): _____

Email Address (if avail.): _____

Emergency Name and Contact Phone Number: _____

Referring Teacher Name: _____

Referring Teacher Phone #: _____Email: _____

Reason(s) for Referral:

Best Day(s) and Time(s) for Tutoring:

MON.	TUES.	WED.	THURS.	FRI.

LOCATION (circle one): BCMS HPS Avon Library Eagle Library

Gypsum Library Vail Library Other: _____

Questions or to return this form contact: The Literacy Project of Eagle County
www.literacyprojecteaglecounty.org **Phone-949.5026 Fax- 949-0233**

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PARENTS COMPLETE THIS PAGE!

Powerschool Release/ Permiso de acceso "PowerSchool"

I _____ parent/guardian of _____ grant permission to Eagle County Schools to release access passwords and logins for Power School grading information to The Literacy Project for my student. This information will be kept confidential and will be used only to support the student's academic success at school.

Yo _____ el padre/la madre o el/la guardián de _____ le da permiso a Eagle County Schools para soltar contraseñas de acceso y logins de "PowerSchool" para informacion academica al Proyecto de Alfabetización para mi estudiante. Esta información se guardará confidencial y sólo se usará para apoyar el éxito académico del estudiante en la escuela.

_____

Parent/ Guardian Signature/ Firma Date/ fecha

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Power School ID Number/ Numero de identificación:_____

Power School Password/ Contraseña: _____

Family Educational Rights and Privacy Act (FERPA) RELEASE/ Permiso de Ferpa (Los Derechos de la Familia Educativa y Acto Privado)

I allow the Study Friends program staff to communicate with the faculty and staff of my student's school about my student for the purpose of obtaining information about his/her academic performance, study habits, classroom behavior, and attendance. I understand that I can revoke these rights at any time, and that this release is valid until the end of the current ECSD school year.

Permito al personal del programa de Amigos de Estudio comunicarse con la facultad y personal de los estudiantes de mi escuela acerca de mi estudiante con el propósito de obtener información de su progreso académico, hábitos de estudio, conducta en la clase y asistencia.

_____

Parent/ Guardian Signature/Firma Date/ fecha