Teen ELECT PARENTING PROGRAM

445 North Reservoir Street, Lancaster, PA 17602 – 717-291-6102 ext. 30308 or
717-419-8816 *Please send to the Teen ELECT Program email teenelect@caplanc.org*

Program Referral Form

All Lines Must Be Completed

Student Name: _____

Social Security: _____

Address: _____

Phone: _____

STU#: _____

Date of Birth: _____

PREGNANT

Due Date: _____

PARENTING

Child's Name: _____ Date of Birth:_____

Child's Name: _____ Date of Birth:_____

School Building: _____

Grade: _____

Referral Source Information

Referred By:

☐ SDoL Staff ☐ Coach ☐ Community Agency ☐ Church ☐Medical Professional

☐ Parent ☐ Self ☐ Other, please explain: _____

Name: _____

Agency/Entity Name (if applicable): _____

Address: _____

Phone Number: _____

Date of Referral: _____

Brief Comments:

***If student is refusing services, please see page 2.**

School District of Lancaster
Together We Can!

Community Action Partnership

pennsylvania
DEPARTMENT OF EDUCATION

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Student Refusal of Services Declaration

The following is to acknowledge that today, I, am refusing services provided by the ELECT/Teen Parenting Program based on the following reasons:

- ☐ Not interested at this time
- ☐ Other, please explain:

If, in the future, I reconsider my option to participate in the program, I will reapply by going to my school nurse, school guidance counselor, ELECT staff, or original referral source.

_____ _____

Student Signature Date

_____ _____

Witness/Staff Date