



Sacramento City Unified School District
CHILD DEVELOPMENT DEPARTMENT

REQUEST for INTERNAL SERVICES (RIS) – *Child/Family*

TO: _____ / _____ <i>Name (Respondent) Title</i>	DATE: _____	<input type="checkbox"/> Education <input type="checkbox"/> Social Services / Mental Health <input type="checkbox"/> Health / Nutrition <input type="checkbox"/> Special Needs
FROM: _____ / _____ <i>Name (Originator) Title</i>	PHONE: _____	
SERVICE REQUESTED: <input type="checkbox"/> Child Observation (<i>requires parent/guardian consent</i>) <input type="checkbox"/> Family Service(s) <input type="checkbox"/> Other		

Child's Name: _____	DOB: _____	<input type="checkbox"/> M <input type="checkbox"/> F
Teacher: _____	Site: _____	<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Head Start <input type="checkbox"/> State <input type="checkbox"/> Wrap <input type="checkbox"/> Full Day
Parent/Guardian: _____	Home Language: _____	Phone Number(s): _____
Parent/Guardian Address: _____		

CONCERN / REQUEST: _____ _____ _____ _____	Screening Results Developmental: _____ Speech/Language: _____ Social/Emotional: _____ Attach copies of ALL Screeners

Refer to Case Management: Yes No

Parent/Guardian's Consent <input type="checkbox"/> I consent to have my child observed and/or screened by any of the following SCUSD professional support staff: <i>resource teacher, behavioral support staff, nurse, coordinator, special education staff.</i> <input type="checkbox"/> I do NOT consent to my child being observed and/or screened. Parent/Guardian Signature: _____ Date: _____

Distribution: White – Respondent (scan to resource team)

Yellow – Child's Classroom File

Pink – Parent