



MIAMI VALLEY CAREER TECHNOLOGY CENTER  
 6800 HOKE ROAD  
 CLAYTON, OHIO 45315

**CAREER ASSESSMENT REFERRAL FORM**

The purpose of Career Assessment is to provide objective information to assist the student, parents or guardians and appropriate persons in setting realistic, relevant, and suitable plans for the future.

**TO BE COMPLETED BY STUDENT** (please print)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Grade in 200\_\_-200\_\_ 9 10 11 12 12+  
 Parent/Guardian \_\_\_\_\_ (e-mail address) \_\_\_\_\_  
 Address \_\_\_\_\_ (street) \_\_\_\_\_ (city) \_\_\_\_\_ (zip) \_\_\_\_\_  
 \_\_\_\_\_ (home phone) \_\_\_\_\_ (cell phone) \_\_\_\_\_ (work phone) School District \_\_\_\_\_  
 What are your vocational interests? (1) \_\_\_\_\_ (2) \_\_\_\_\_  
 Are you interested in attending the MVCTC for training? (Circle one) YES NO

**TO BE COMPLETED BY PARENT \*\* PERMISSION \*\*** (check to indicate your choice)

\_\_\_\_ I give permission for my child to take part in a career assessment, and give consent for the release of assessment information to the referring school personnel.  
 \_\_\_\_ I do not give permission for my child to take part in a career assessment. [When checking here, disregard the following sections and sign and date bottom.]

**TO BE COMPLETED BY PARENT \*\* MEDICAL INFORMATION \*\*** (please print)

Please list any physical or medical problems your child has: \_\_\_\_\_  
 Does your child take any medication during school hours? If yes, please list the type and dosage. Yes \_\_\_ No \_\_\_  
 Type & Dosage: \_\_\_\_\_  
 In the event my child needs medical attention, please contact: \_\_\_\_\_ Phone # \_\_\_\_\_  
 If the medical professional above is unavailable, my signature at the bottom of this form gives consent for my child to be treated by a licensed physician or dentist at any accessible hospital.

**TO BE COMPLETED BY PARENT \*\* CONFERENCE \*\*** (check to indicate your choice)

At the completion of the evaluation process you will be invited to a post evaluation conference.  
 \_\_\_\_ I would like to attend. Please notify me by mail as to the date, time, and location of conference.  
 \_\_\_\_ I will be unable to attend. Please send me a copy of the evaluation report.

Signature – Parent/legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY HOME SCHOOL REFERRING PERSON**

What questions would you like answered by this assessment? \_\_\_\_\_  
 Other accommodations: Wheelchair \_\_\_ Aide \_\_\_ Interpreter \_\_\_ Other \_\_\_\_\_  
 Is this student involved with Children's Services? Yes/No If yes, Caseworker's name, agency and address: \_\_\_\_\_  
 \_\_\_\_\_  
**Services Provided** (Circle which applies): Tutored Only Resource Room Inclusion setting  
 Resource Room (list subjects): \_\_\_\_\_  
 Inclusion setting (list subjects): \_\_\_\_\_

**Attach the following to this application:** Date received at M.V.C.T.C.  
 1. Recent Multi-factored Evaluation Team Report (most recent) \_\_\_\_\_  
 2. Current IEP (Please include EMIS data information) \_\_\_\_\_

Signature – Home School Referral Person: \_\_\_\_\_ Date: \_\_\_\_\_