



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

CAREER ASSESSMENT/VOCATIONAL EVALUATION 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: _____
 EMIS ID # or Social Security # _____ (required) Grade in 20__-20__ 9 10 11 12 12+
[obtain EMIS ID # from school counselor]

Parent/Guardian _____ (parent 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:
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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 (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:** _____