Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

Advanced Academic Programs School-Based Services

Subject-Specific and Part-Time AAP Services Referral Form

Please print clearly or type; referral form may not be retyped. Responses must fit on this form. No attachments.

Student Full Name ________________________________ **Date of Birth** ____________________

Student ID ______________________ **Current School** ________________________________

Grade ________ **FCPS Classroom Teacher** ____

FCPS Advanced Academic Resource Teacher ______________________________________

Parents/Guardians ____

Telephone ___________________________ **Email** ______________________________

Home Address ____

In the space below, please provide information to support the committee's understanding of your student's learning needs. Suggestions include examples of critical and creative thinking, areas of strength, languages spoken by the student, a summary of how special learning needs, such as the need for an IEP or 504 Plan, might impact the student's performance.

Signature of Referral Source ____

Relationship to Student _______________________________ **Date of Referral** ________________