

STUDENT SERVICES CENTER
TROUP COUNTY SCHOOL SYSTEM
STUDENT DISCIPLINARY CONFERENCE REFERRAL

SCHOOL NAME _____ ADMINISTRATOR _____

STUDENT'S FULL NAME: _____

STUDENT ID # _____ GRADE _____ SEX/ETHNIC ORIGIN _____

AGE _____ DATE OF BIRTH _____

ADDRESS (please verify with student) _____

PHONE NUMBER (please verify with student) _____

PARENT/GUARDIAN NAME _____

REGULAR ED _____ EXCEPTIONAL ED _____ 504 _____ SST _____

IF YES, GIVE DATE OF MANIFESTATION DETERMINATION MEETING: _____

OFFENSE(S) _____

DATE OF OFFENSE _____ TIME OF OFFENSE _____

HAVE POLICE/SHERIFF'S OFFICE BEEN NOTIFIED? _____ WHEN _____

PLACEMENT: ISS OR OSS DATE OF PLACEMENT _____

BRIEF SUMMARY OF INCIDENT _____

*****FOR STUDENT SERVICES USE ONLY*****

DATE/TIME OF CONFERENCE: _____