ELECT REFERRAL FORM
EXPECTING/PARENTING STUDENT

Date: _____ Student ID # _____

Student Name: _____ DOB: _____

School: _____ Grade: _____

School Counselor: _____

Referred By: _____

Parent/Guardian: _____ Notified of referral? Yes No

Address: _____

Home Phone: _____ Work Phone: _____

EDC (due date): _____ Health Provider Verification? Yes No

Does student already have a child? Yes No Child's DOB:_____

Comments/Additional Information: _____
_____
_____
_____

Send Completed Form to:
Community Liaison
ELECT Program

Wm. Allen H.S.
106 N. 17th St.
Allentown, PA 18104

ELECT Program Use only:

Eligibility

TANF_____ Food Stamps_____ Family Works_____ EFI_____

Referral

Nurse-Family Partnership_____ Family Centers_____ Early Head Start_____ Other_____