

**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 _____