Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

Advanced Academic Programs
Full-Time AAP Services Referral Form

Student Full Name _____ **Date of Birth** _____

Student ID _____ **Current School** _____

Grade _____ **FCPS Classroom Teacher** _____

FCPS Advanced Academic Resource Teacher _____

Parent/Guardian _____

Telephone _____ **Email** _____

Home Address _____

Screening for Subject-Specific and Part-Time AAP Services takes place at FCPS elementary school sites. Contact the local school Advanced Academic Resource Teacher for information.

- In the space below, please provide information to explain why the student should be considered for Full-Time AAP services. Include information to support the committee's understanding of your student's learning needs. Suggestions include examples of critical and creative thinking, area(s) of strength, languages spoken by the student.
- Please note that FCPS School staff cannot disclose information about a 504 Plan or IEP without permission from a student's family. If you would like the school to share information about your student's learning disability, accommodations, or a segment of your student's IEP, please email the AART and principal of your school to provide written consent.

Name and Signature of Referral Source _____

Relationship to Student _____ **Date of Referral** _____