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 _____ **Classroom Teacher** _____

Parent/Guardian Name(s) _____

Telephone _____ **Email** _____

Home Address _____

All information must fit in the space provided below; attachments or additional pages will not be accepted. Please explain why the student should be considered for Full-Time AAP services. Include details to help the committee understand your child's learning needs (e.g., examples of critical or creative thinking, areas of strength, languages spoken).

FCPS staff cannot share information about a 504 Plan or IEP without parent/guardian permission. If you want this information included, please complete the *Family Consent to Share IEP/504 Information Form.*

Name and Signature of Referral Source _____

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