Champaign/Ford Regional Office of Education
Abolish Chronic Truancy (A.C.T.) Referral

School Information

District/School_____

Name & Title of Person Making Referral_____

Phone Number of Person Making Referral_____

Date of Referral _____

School District Sign-off _____

Student Information

Last Name_____ First Name_____

Middle Initial_____ Male_____ Female_____

Date of Birth_____ Age_____ Grade_____

Home Address_____

Parent/Guardian Information ACT Letter will be sent to this person(s)

Name_____

Home Address_____

Phone Number_____

Relationship to Student_____

_____

Student Attendance

Number of School Attendance Days Possible_____

Number of Unexcused Absences_____