



2009 Student Referral Form

Please return via Fax to (518) 854-3347
or send as an email attachment to aprildoin@nycap.rr.com

Please print and complete all information requested. All information is required!

Student Name _____

Student Grade 10th-Sophomore 11th-Junior 12th-Senior

Student Home Street Address _____

City _____ Zip Code _____

Home Phone _____ High School _____

County of Residence: Albany Rensselaer Saratoga Schenectady Greene

Columbia Fulton Hamilton Montgomery Schoharie Warren Washington

Does the student have any special needs we should be aware of? _____

If Yes, Please Describe _____

Referred By (Name and Title) _____

Referring School or Organization _____

Address _____

Telephone Number _____

Referring Person E-Mail Address _____

*The Cinderella Project of the Capital Region respects the privacy of all students. No student information will be published or used in any manner, with the exception of contact for participation in our program, without explicit consent from the student and school.

Once Upon a Time is Now.....