CONSENT FOR CLINICAL SERVICES
NEVADA SCHOOL DISTRICT

Student's Last Name	First Name, MI	Student ID #	Teacher/Grade

I authorize my child's participation in therapeutic groups or individual sessions at school. A qualified mental health provider will complete an assessment and recommendations to support your child's academic success. These services will be provided free of charge to your child.

In partnership with you and your child, the school's multi-disciplinary team will develop a plan of care (POC) to provided group or individual sessions focusing on self-awareness, self-management, social awareness, relationship skills, and responsible decision-making. We are requesting permission to meet with your child to determine if your child is eligible for services listed above. If you agree for your child to receive services from our school-based counseling staff, please sign and return this form.

If you have any questions, concerns, or suggestions, please do not hesitate to contact me______________________________________ at ____________________ or via e-mail at _________________________________. I also welcome parent/guardian visits to my office, so feel free to call and we can arrange a time to meet.

Please check one of the statements below, sign, and return the entire form to school with your child. Thank you!

___ I **DO** give permission for my child, ____________________________________, to receive therapeutic services at school. Consent for services will be valid for one year from today's date. We will be in contact with you directly to complete the assessment and develop a plan of care. We will also contact you to review your child's progress and discuss further recommendations. Permission can be withdrawn at any time with written notice to the school-based qualified mental health provider. I understand that counseling information is confidential and HIPPA and FERPA privacy rights will be followed

___ I **DO NOT** give permission for my child, ______________________________, to receive therapeutic services at school.

__________________________________ __________________________

Parent/Guardian (Print Name) Date

__________________________________ __________________________

Parent/Guardian (Signature) Phone Number

Please return to the school-based qualified mental health provider

SAMPLE

NOTE: The services offered are **not** to replace outside therapeutic services your child may already be receiving within the community. If your child is receiving therapy services in the community, it is our goal to work with you and your provider to help your child's academic success. These services are being offered in attention to and in partnership with your outside therapeutic provider. All school-based services are free of charge. Thank you.

SAMPLE

Please return to the school-based qualified mental health provider