Leon County Public Schools
School Counseling Consent Form

Date:

Student Name:

Parent/Guardian Name:

Leon County School District school counselors, school social workers, school psychologist and other mental health professionals offer short-term individual counseling to students as well as small group counseling aimed at facilitating the student's academic, personal, and social development within the school community and learning environment. Parents or school staff may refer students for counseling or students may request counseling services themselves. These services are

Please read and check all boxes below if consenting:

- ○ I understand that school counseling services are short-term.
- ○ I understand that these services are not intended as a substitute for diagnosis or treatment for any mental health disorder.
- ○ I acknowledge it is my responsibility as the parent to determine if additional or different services for my child are necessary, and that I must decide if I want to seek them out for my child.

In order to build trust with your child, the student services provider (School Counselor, School Social Worker, School Psychologist or other mental health provider) will keep information confidential, except in certain situations in which ethical responsibility limits confidentiality.

- ○ I understand that the student service provider may share information with parents, your child's teacher, administrators, and/or school personnel who work with your child on a need to know basis, so that we may work as a team to better assist and support your child. The student service provider is required by law to share information with parents or others in the event the child is in danger of harm to self or others or if there is concern for your child's mental, emotional or physical health. The school service provider will make your child aware of these limits to confidentiality.

Please check one:

- ○ I GIVE PERMISSION for my child to receive school counseling services through Leon County Public Schools. I understand that I may withdraw my consent at any time by signing and dating a written note requesting termination of counseling services.

- ○ I choose to DECLINE school counseling services for my child at this time. I understand that I may request counseling services at a later date if needed.

_____

Parent Signature Date

_____

Email Address Daytime Phone

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Student Services Provider Email Address Daytime Phone