Windber Area School District
Assurance Counseling Services, LLC

Middle School/High School Mental Health Services
Parent/Guardian Consent

Child's Name: _____
Child's Date of Birth: _____
Child's Grade/Homeroom Teacher: _____

It is a policy of Windber Area School District and Assurance Counseling Services LLC to gain consent from parents to be able to provide mental health services to children under the age of 18 years. This is a referral-based service. You, your child, or concerned teacher can make this referral. This is a confidential service.

- I am signing to acknowledge that I am giving my consent as biological parent or guardian, to allow him/her to receive mental health services through Windber Area School District from Assurance Counseling Services LLC.

- Parents/Guardian(s) will be contacted by an Assurance Counselor to keep you informed and updated throughout the services. If an emergency or crisis situation occurs, you will be contacted after the safety of your student and others is ensured.

- I am aware that I am able to contact the office at any time to inquire about mental health services and receive updates. I may revoke this consent in writing at any time.

_____	_____	_____
Parent/Guardian Signature	Date	Relationship to Student

_____	_____	_____
Parent/Guardian Signature	Date	Relationship to Student

(2nd Parent signature needed if both parents do not live in the same household)

Check below to indicate your reason for signing this consent:

_____ My child does Not currently need services; please keep on file

_____I am requesting services begin with Assurance Counseling Services; please contact me

Please contact me by phone or email: _____
Phone or email contact information

R. 12/27/18