Trinitas Regional Medical Center
In-School Counseling Program

PROGRAM CONSENT FORM

I hereby give consent and authorization for my child:

NAME OF STUDENT: _____

ADDRESS:_____

_____

_____

PHONE NUMBER: _____

SCHOOL: _____ GRADE: _____ TEACHER: _____

To participate in services provided by the Trinitas Clinician and I agree that the Clinician and the school personnel involved with my child may share appropriate information. I am aware of the limitations of in school counseling services and understand that this service is not in lieu of more intensive outpatient services.

O I wish to speak to the counselor before my child is seen.

_____ _____
Parent/Guardian Witness

_____ _____
Date Date

_____ _____
School Based Clinician Date