VALLEY | CITIES
Behavioral Health Care

PARENTAL PERMISSION SLIP FOR RECEIVING SERVICES AT SCHOOL

Dear Parent(s) / Guardian:

By signing this form, you are providing permission for your child to receive behavioral health services from our agency, Valley Cities Counseling & Consultation, in the school setting. We are a non-profit, community-based agency that provides group, individual, and family therapy services. In an effort to be accessible and respond to the needs of the community, we offer a variety of treatment services within the school setting. **Sessions are scheduled on a weekly or bi-weekly basis, as appropriate, based on your child's needs.** We are sensitive to the academic needs of each child and will consider educational and classroom priorities when scheduling appointments. Our agency works closely with school personnel and parents/legal guardians to ensure that your child's academic and emotional needs are being met simultaneously. Any curriculum used in the course of counseling services is not the approved curriculum of the District, and Valley Cities takes responsibility for its content. The school district does not supervise therapy services in any way.

Please sign the consent below and return it to the school or the Valley Cities clinician to initiate services at school, as appropriate. Copies will be provided to the school, school district, and Valley Cities clinician listed below.

Children are more likely to reach therapeutic goals with support from multiple areas. Although your child may be seen at school, please talk with your child's clinician about a plan to stay in contact while services are being provided or to arrange services outside of the school setting.

My child's clinician, ________________________, and I will abide by the following plan of contact, phone calls as needed. while____________________________(client) is receiving school based services from Valley Cities.

If you have further questions, please talk with your child's school or contact the Valley Cites Clinician listed below.

Sincerely, ______________________________________

I give my child,__________________________, permission to participate in behavioral

health services at ____ school.

Your school contact ____

Valley Cities Contact ___________________________________Phone ___________________

Printed Name of Parent/Guardian ____

Signature of Parent/Guardian ___________________________________ Date:___________