

STUDENT ASSISTANCE PROGRAM PARENT PERMISSION FORM

Middletown Area School District

I give my permission for my child, _____, in grade _____,
(Student's name – PLEASE PRINT)

to participate in the Student Assistance Program (SAP) of the Middletown Area School District, as explained to me by a member of the Student Assistance Team.

I understand that:

- SAP is designed to identify students who are experiencing barriers to learning and school success.
- my child's Student Assistance Team will intervene and refer my child to the appropriate school or community resources.
- SAP is a voluntary intervention program, not a treatment program.
- parent permission and involvement is necessary.
- the SAP team does not diagnose or treat students.

I give permission for:

- my child to meet with a member of the Student Assistance Team and ad hoc members from Keystone Human Services and/or Dauphin County Drug and Alcohol.
- the Student Assistance Team to release relevant information from his/her record for the purpose of a Student Assistance Program assessment. I understand that Student Assistance information will be handled in a confidential manner. I understand that the results of this assessment will be disclosed to me through communication with either a SAP Team member or staff member completing the assessment.

I understand that this permission is valid for one year from the date of my signature and I may withdraw this permission at any time.

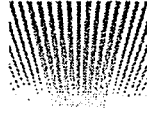
Parent/Guardian Name (PLEASE PRINT): _____

Parent/Guardian Signature

Date

Please return this form within 7 days to your child's school.

Teamwork means that we share a common ideal and embrace a common goal. Regardless of our differences, we strive shoulder to shoulder, confident in one another's faith, trust, and commitment. In the end, teamwork can be summed up in five short words... "We believe in each other."



K E Y S T O N E
H U M A N S E R V I C E S

"Advancing the Human Spirit"

Your child has been referred to The Student Assistance Program (SAP) at his/her school. In the event that the SAP team feels your child could benefit from an informal mental health assessment one will be conducted by the mental health consultant with your written permission. Upon completion of the informal assessment, the mental health consultant will contact you to offer recommendations for you to consider.* The mental health consultant *does not* provide counseling or mental health treatment. **In order for the assessment to take place Keystone needs your written permission below.**

The assessment is free of charge and will take place during the school day at your child's school. Any Student Assistance information will be maintained in the strictest confidence.

Thank you for your cooperation.

*According to PA law, a student the age of 14 or older has a right to decide how much information is shared and with whom after the assessment.

KEYSTONE HUMAN SERVICES
Student Assistance Program – Informal Mental Health Assessment
PARENT PERMISSION FORM

I give my permission for my son/daughter _____
(Name)

to meet with a mental health consultant from Keystone Human Services, Student Assistance Program in order to participate in an informal mental health assessment.

Parent/Guardian Printed Name

Parent/Guardian Signature

Date