STUDENT ASSISTANCE PROGRAM
PARENTAL CONSENT FORM

The Student Assistance Team of the Reynolds School District strives to assist students in succeeding in the education process. Your son/daughter has been referred to the Student Assistance Program because of concerns regarding school performance. At times, students who are having problems in school may also be experiencing difficulty with other personal issues such as self-esteem, depression, substance abuse, bereavement, or relationship problems.

The students and families have the opportunity to participate with the Student Assistance Team. This program is voluntary, and works with the student, family, school and community resources, to assist the student in achieving a more successful school experience.

Please indicate your permission for your son/daughter to participate in the Student Assistance Program.

Child's Name: _____

Parent/Guardian Name: _____

Address: _____

Telephone: _____

I, hereby authorize Mercer County Behavioral Health Commission's school liaison to meet with my child, _____. This screening will take place during school hours and there is no cost for this service. ***I also agree to meet with a MCBHC liaison within a week's time following the initial screening.***

Parent/Guardian_____ _____
Date

SAP Signature _____ _____
Date

_____ I **do not** want any services for my child at this time.

Parent/Guardian _____ _____
Date