PERMISSION TO PROVIDE COUNSELING

STUDENT NAME:

DATE:

PARENT CONTACT INFO:

I, _____, as the parent/legal guardian of _____, give permission to the counselor/school psychologist of Ansonia Local Schools, a mental health therapist from the Darke County Educational Service Center (ESC) or Darke County Recovery and Wellness to provide counseling support to my child. I understand that the counseling services provided are for the support of the student and not for diagnosing a mental illness or condition. The counseling services will begin on / / . Counseling services will end on / / or when counseling is no longer deemed necessary by the parent or school district.

_____ _____

PARENT SIGNATURE *Date*

_____ _____

SIGNATURE OF COUNSELOR/STAFF MEMBER *Date*