Alachua County Public Schools

Student Support Services

Consent for Services

School Name:_____

School Number:_____

Date:_____

Student Being Referred:_____ Date of Birth:_____

Student Number:_____ Grade:_____

Parent/Guardian:_____ Home Phone:_____

Address:_____ Cell Phone:_____

City/State/Zip:_____ Business Phone:_____

Referred By:_____ Title:_____

Your child has been referred to the:

- ☐ School Counselor for the purpose of providing him/her with additional professional support services including consultation, counseling, and case management, as needed.
- ☐ Speech and Language Pathologist to provide a speech and language screening.

Concerns for your child are in the following area(s):

- ☐ Achievement
- ☐ Behavior Social Life Skills
- ☐ Other – Explain:_____

If you have questions or wish additional information please call *(phone)*:_____

Administrator/Designee_____ Date:_____

Signature

Please return this form to the School Counselor.

PARENT / GUARDIAN CONSENT

Check One:

- ☐ Permission is given for the service
- ☐ Permission is denied for this service
- ☐ I request a conference to discuss this matter

Parent/Guardian:_____ Date:_____

Signature

You may withdraw consent at any time by contacting the appropriate Student Services personnel.