

## Confidential Parent Consent for Mental Health Care Services for a Student

**Note to administrator:** This sample form is to be filled out by a parent when the threat assessment and safe and supportive school team determines that a student who is under the age of 18 would benefit from mental health care services.

On \_\_\_\_\_ (date), the District's threat assessment and safe and supportive school team determined that \_\_\_\_\_ (student name) would benefit from mental health care services that can be provided by this team. These services include:

**[Include and describe services to be provided to the student.]**

**Note:** To proceed with the request for the services described, your written consent is necessary. Your consent is voluntary, and if you choose not to have your child receive mental health services, it will not affect your student's or your family's relationship with the school, the student's academics, or any other punitive consequence. You should only provide consent if you understand the services being offered and have had the opportunity to ask questions.

### Parental Consent for Services

I understand that I may withdraw this consent at any time. Unless consent is withdrawn, this consent will be effective for the remainder of the school year. If major changes in services are proposed, a new consent will be required. I give my voluntary consent for the services described and understand that I may withdraw my permission at any time.

#### Choose one of the following:

- ☐ Yes, I give permission for my child to receive ongoing mental health care services described above.
- ☐ Yes, I give permission for my child to receive mental health care services, but the services shall be limited as follows:
- Services: (Describe the services to be allowed.)
  - Duration: (Describe in terms of specific units of time the number of services that can be provided without seeking additional consent, for example, 15 minutes, one hour.)
- ☐ No, I do not give permission for my child to receive mental health care services.

SAN FELIPE DEL RIO CISD  
233901

STUDENT WELFARE  
CRISIS INTERVENTION

FFB  
(EXHIBIT)

Parent's or guardian's printed name: \_\_\_\_\_

Parent's or guardian's signature: \_\_\_\_\_

Parent's or guardian's  
contact information: \_\_\_\_\_

Date: \_\_\_\_\_

School District official's printed name: \_\_\_\_\_

School District official signature: \_\_\_\_\_