**LIVINGSTON COUNTY**

**Consent for Counseling Services**

**Student**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Based upon an identified need from one or more of the following sources, counseling services have been recommended:

School Personnel

School Counselor

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The requested counseling services will be provided by the following individual:

**Agency/Counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Area of Expertise:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This counseling will be offered on an as needed basis for approximately thirty minutes a session. Participants will have the opportunity to learn new skills and behaviors that may help their personal development and adjustment. The counseling topics will focus on as appropriate to the individual: anger management, conflict resolution, communication skills, family interactions and relations, and interpersonal skills.

Because counseling is based on a trusting relationship between counselor and client, the information shared will be confidential except in certain a situation in which there is an ethical responsibility to limit confidentiality. Examples of when confidentiality may be limited include:

* If information is revealed about hurting him/herself or another person
* If information is revealed about child abuse
* If information is revealed about criminal activity
* If information is revealed about domestic violence

Consent will allow your child to participate in counseling. This will provide an opportunity for the student to learn and practice interpersonal skills, discuss feelings, share ideas, and practice new behaviors. Anything the student shares in the session will be kept confidential except for the above mentioned circumstances.

Please list the name and age of the student that will be participating in the counseling session:

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I have been informed in my native language, or preferred mode of communication, and understand the contents of this consent. I understand that I may revoke consent at any time by notifying the building administrator or designee.

* Yes, I/we do give consent for counseling services.

**No, I/we do not give consent for counseling services.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Signature Date

Please return to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_