



GENEVA CITY SCHOOLS OPT-IN FOR MENTAL HEALTH SERVICES

As of the date of my signature below, my child, _____, is under the age of 14 years old:

Yes

No

- If No, skip the next section and sign at the bottom of the page.
- If Yes, continue below.

I hereby give my permission for my child to participate in the following mental health services: [Check the box for each mental health service you want to be available to your child]

Assessments/Surveys – includes questionnaires provided to students related to social behaviors, feelings, etc.

Crisis intervention - short-term, immediate assistance by a school counselor or professional for a specific situation.

School-Based Mental Health - On-going counseling services by school professionals or private practitioners in the school setting. The parent or legal guardian's permission will be obtained during an intake meeting before services are provided. You may rescind permission for a student to participate in mental health services at any time by providing written notice to the school administration.

Parent/Guardian Name (Printed)

Parent/Guardian Name (Signature)

Date: _____

** Please return to your child's school.*