



# CONSENT FOR ONGOING SCHOOL COUNSELING

FORM 20

ARCHDIOCESE OF WASHINGTON – Catholic Schools

St. Raphael School offers ongoing school counseling services to students. Parents/guardians or school staff may request counseling for a student, or students may request counseling services. In either case, a student's parent or guardian must read and sign this form prior to the commencement of school counseling sessions, to acknowledge and consent to ongoing school counseling that may be rendered to the Student by the School Counselor.

## Acknowledgment and Consent

I, \_\_\_\_\_ acknowledge and consent to ongoing

*Print Your Name*

school counseling services that may be rendered to \_\_\_\_\_

*Print Student's Name and Grade Level*

(the "Student") by the School Counselor, and I understand that ongoing school counseling services are aimed at the more effective education and socialization of my child(ren) within the school community. Also, I understand that these services are not intended as a substitute for diagnosis or treatment for any mental health disorder.

In order to build trust with the Student, the School Counselor will keep information shared with them by Student confidential, with some possible exceptions, including: when authorized school personnel have a legitimate, educational need to have the information; when a student intends to harm himself/herself or another individual; when necessary to prevent serious and foreseeable danger; when a parent of a student or an emancipated student provides a written statement authorizing the release of information; or in other situations as required by law. If the Student receives school counseling within a group setting, confidentiality is difficult to maintain outside of the group meeting, and the School Counselor will make the Student aware of these limits to confidentiality.

I understand that I will be asked to sign an additional authorization of release of information form that is provided by the school should the School Counselor receive a request from me or from another individual to share information with a third party, such as a family counselor, psychiatrist, social worker, or pediatrician.

When necessary and appropriate, the School Counselor may suggest that a referral to outside counseling resource(s) is in the Student's best interests. I understand that the School Counselor will inform me of a reasonable amount of applicable resources and will provide reasonable assistance to minimize interruption of counseling services.

I, hereby, acknowledge and consent for the ongoing counseling services as described above and this consent will be in effect for the duration of the Student's enrollment in the School listed above. I also understand that I may withdraw this consent at any time by providing a signed and dated written request for immediate termination of participation in the ongoing counseling services.

Name of Parent/Guardian: \_\_\_\_\_

*Please Print*

Signature of Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

*Sign Your Name*

*Today's Date*