Consent to Gateway To Success Services

Alhambra Unified School District, Gateway To Success program provides counseling services to students in need of additional social/emotional support. Please read this form carefully and provide all the requested information to allow your child to receive health services at school.

Student/Client Information

Name:_____ Date of birth:_____ Grade:_____

Address:_____

Cell Phone:_____Home:_____Email:_____

Parent/ Legal Guardian/ Caregiver Information

Name:_____

Address:_____

Home Phone:_____Cell:_____Work:_____

1. I give permission for Gateway To Success to provide any of the support services listed below, except as noted, to my child. This includes consent for any of the following, when advised or recommended by Gateway To Success designee:

   - Mental health services, including screening, assessment, and counseling
   - Psycho-education and small counseling groups
   - Health and wellness education
   - Academic and behavior management support
   - Referrals for counseling services to designated mental health agencies (including disclosure of insurance and/or social security number)

Except I DO NOT want my child to receive the following services from the above list:

_____

If you do not want your child to receive one or more of the above services, please list here.

2. I understand my consent covers only those services provided through Gateway To Success on a voluntary basis only. I understand that I can change my mind later on and decide I do not want my child to get services through Gateway To Success. If I change my mind, I will let the Gateway To Success designee or school official know in writing by sending a letter to my child's school of attendance or mail to the district office Attn: Gateway To Success 1515 West Mission Rd., Alhambra CA 91803. I understand that this consent form remains valid until ____/____/____ or until Gateway To Success receives a written revocation from me.

3. I understand that in order to provide the highest quality of services, sessions may be audio/videotaped and reviewed by clinical supervisors and counseling interns for training purposes. Only the intern will be the subject of any videotaping although your child's voice will be heard. The Gateway To Success team feels that this commitment to training best guarantees the highest quality of services.

Student Signature: _____ Date: _____

Print Name:_____DOB: _____

A student must sign consent if 12 years or older.

Parent/Guardian Signature: _____Date: _____

Print Name:_____ Relationship to Student:_____

FORM A

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