Alhambra Unified School District
1515 W Mission Rd, Alhambra, CA 91803 (626) 943-3410
Informed Consent for Gateway To Success Services

Student Name: _____ DOB: _____

School: _____ Grade: _____ ID#: _____

Gateway To Success (GTS) is a counseling service that is offered to students and is a part of Alhambra Unified School District. The goal of GTS is to provide social-emotional support in order for students to succeed in the educational setting.

I give permission for GTS to provide any of the support services listed below. This includes consent for any of the following, when advised or recommended by GTS designee:

- Mental health services including assessment, individual counseling, and small groups
- Wellness and psychoeducational opportunities (workshops, webinars, mindfulness, etc.)
- Academic and behavior management support
- Check-in with student as needed
- Referrals for therapy services to designated mental health agencies (including client demographic information and/or disclosure of insurance and social security number)

Your signature below indicates your knowledge of, and consent to the following:

I understand that a pre-licensed, graduate, or postgraduate level Intern may provide school based counseling during school hours under supervision by a licensed mental health professional. I understand that Interns may share information with their Supervisors for learning/educational purposes which may include documentation, assessments, and audio/video observations.

I further recognize and understand that all information disclosed within sessions is confidential and may not be revealed to anyone outside of GTS of the Alhambra Unified School District without written consent from myself, except when disclosure is required by law (i.e., when there is reasonable suspicion of abuse of children or elderly persons, and when the client presents a serious danger to him or herself, another person, or to property). GTS may, in the interest of school safety, share issues involving safety within the school community with school administrators.

I understand that, at times, it may be in my child's best interest for GTS to disclose some information to his/her teacher(s), school psychologist, school counselor, nurse, or administrator(s). In such circumstances I give my permission for GTS to release information to school personnel including verbal and electronic information that the student is receiving school based counseling support. GTS staff are professionals and use the best interest of the child as their guiding principle.

I understand that GTS may need information contained in your child's educational record including contact information, attendance records, discipline record, class schedule, transcript, health and special education records, and testing results in order to better assess special needs, coordinate care, provide treatment or referrals, and/or evaluate provided services.

I understand that the effectiveness of counseling services and my child's progress may be monitored by pre/post-tests. Assessment tools may be utilized to determine treatment goals, planning, and progress.

I understand that sessions may be audio/video recorded and reviewed by Interns and Clinical supervisors for training purposes. Only the Intern will be filmed on video, although your child's voice will be heard.

_____**Yes, I <u>DO</u>** consent to audio/video recording of my child during session

_____**No, I DO <u>NOT</u>** consent to audio/video recording of my child during session

Telehealth Contingency Plan: In the event that the client and therapist cannot meet face-to-face, sessions may need to be held via telehealth.

Telehealth services are used when mental health staff cannot be physically present with you to evaluate your mental health needs and provide weekly sessions. Mental health staff may be present at another location and available to serve you through newly available technology. Instead of talking to someone on the phone at another location, Telehealth services use a video camera and computer to send both voice and personal images (pictures) between you and mental health staff so not only can you talk to each other, but you can also see each other. This allows mental health staff to make a better evaluation of your needs.

I have read and reviewed the Additional Telehealth Consent Form _____

<u>I understand all of the above services are voluntary and I have the right to pursue other services or to withdraw consent at any time.</u>

_____**Yes, I <u>DO</u>** consent to counseling support during school hours

_____**No, I DO <u>NOT</u>** consent to counseling support during school hours

Signature of Student	**Date**	
Signature of Parent/Guardian	**Date**	**Daytime phone number**
Print Name of Parent/Guardian	**Relationship to student** (ex; father, mother, stepfather/mother, legal guardian, grandparent, foster parent, etc.)	

As the child's parent, if you are unmarried, divorced or legally separated, do you have:
___ sole legal custody ___ joint legal custody ___ I do not have legal custody ___ there are no formal arrangements

If you have joint legal custody, do you have a joint consent provision in your custody order requiring both parents to consent for counseling services or educational decisions? _____ yes _____ no

(****If you have joint legal custody**, it is the parent's responsibility to inform the AUSD if there is a joint consent provision in your custody order that requires the consent of both parents for your child to obtain counseling services. Failure to disclose this information to the AUSD may be a direct violation of your custody order and may have legal consequences for you.)

As the child's guardian, do you have court documents stating that you have legal guardianship?
____yes ___no