General Consent for
Gateway To Success (GTS) Services

GTS Use Only
ID#: ___________

Client Information
Name:_______________________________ Date of birth:__________ Grade:_____

Address: ____

Cell Phone:_________________________ Home Phone: ______________________

Parent/ Legal Guardian/ Caregiver Information
Name:____

Address: ____

Best phone contact: _________________________ Work phone: _________________

Email:___________________________

Directions: All statements need to be reviewed and initialed by Parent/Guardian. Parent/Guardian to initial in first bracket and client to initial in second bracket (if client is 12 years or older). Some permissions are required in order to initiate services. Only **ONE** Parent/Guardian per consent form.

1. [___] [___] I give permission for GTS 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 GTS designee:

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

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

   ____

2. [___] [___] I understand in order for my child to receive school-based mental health services, my child will be seen during instructional time within the school day. I understand any assignments my child may have missed from class can be requested for make-up. I understand my child's therapist/provider is responsible for ensuring my child was not marked absent from class during therapy time.

3. [___] [___] I understand my consent covers only those services provided through GTS on a voluntary basis. I understand that I can change my mind later on and decide I do not want my child to receive services through GTS and notify my child's school. I understand that this consent form remains valid until ____/____/____ or until GTS receives a written revocation from me.

4. [___] [___] I understand that in order to provide the highest quality of services, sessions may be audio/video recorded and reviewed by clinical supervisors and clinical interns for training purposes. Only the intern will be filmed on video, although your child's voice will be heard. GTS feels that this commitment to training best guarantees the highest quality of services.

When Parent/Guardian independently initiated services through an outside agency provider (not through GTS):

[___] [___] I understand that ________________________ (Agency) will need to exchange information with GTS and my child's school. I give permission for my child to be seen during instructional time during the school day for mental health services.

Client Signature: ____________________________________ Date: ________________

A client must sign consent if 12 years or older

Print Name: ____ DOB: ________________

Parent/Guardian Signature: ___________________________ Date: ________________

Print Name:__________________________ Relationship to client:___________________