



**SCHOOL PARTNERSHIP PROGRAM
(SPP)**

9200 Watson Rd., G-101
St. Louis, MO 63126-1528
P: 314.544.3800 **F:** 314.843.0552

(rev 5-1-18)

Consent Form: Parent/Guardian

Note: Please read and sign both sections.

I give permission for my child _____ to
participate in counseling services with Saint Louis Counseling' school counselor.

Counseling services will be provided at _____ School.

Parent/Guardian's Name (Please Print) _____

Parent/Guardian's Signature _____

Phone Numbers: _____

Best Time to Contact: _____

Today's Date: _____

I give permission for the therapist to speak with and/or write to the principal, or other referring school personnel for the purpose of sharing information that will help the school staff understand and work with my child. This consent will remain in effect until counseling is terminated.

Parent/Guardian's Signature _____

Today's Date _____

Some case records may be used for auditing purposes. All records will be kept in strictest confidence, however.

