KELLENBERG MEMORIAL HIGH SCHOOL
1400 Glenn Curtiss Boulevard □ Uniondale, New York 11553-3702
Phone: (516) 292-0200 ♦ Fax: (516) 292-0877 ♦ www.kellenberg.org

Request for School Psychologist Support: Parent Initiated

Dear Mr. Lyons,

I would like to request that my child be permitted to see the School Psychologist. In making this request, I am authorizing the School Psychologist to meet with my son or daughter during school hours. He/She may speak to teachers, counselors and others significant in the life of my child. I understand that this service is limited and cannot be ongoing in nature.

Student's Name: _____

Student's Grade: _____ Student's Date of Birth: _____

Student's Address:_____

Reason for request:

_____
_____
_____
_____
_____

I give consent for my child to receive counseling services from the School Psychologist.

Printed Name of
Parent/Guardian:_____

Relationship to student:_____

PARENT/GUARDIAN SIGNATURE:_____

Date:_____ Parent/Guardian Contact:_____

This consent is valid for a period of one (1) year