IONE Junior High School

HOME OF THE COLTS

450 S Mills St, Ione, CA 95640

Dear Parent/Legal Guardian of _____, date of birth_____

Your child has the opportunity to receive counseling services at **Ione Jr High School** by the school counselor, **Susana Flores.** With your permission, counseling provided may include the following services checked below:

- ❑ Individual counseling (2-4 times a month for 20-40 minutes each session)
- ❑ Group counseling (e.g. usually last 6-8 weeks, 1 time a week, 30-40 minutes each session)
- ❑ Academic and/or Behavioral Consultation (e.g. 1 – 2 time a month consultations with teachers and other staff members to promote academic and/or behavioral improvements)

The focus of the counseling revolves around empowering students to overcome obstacles at school, in their community, and/or other challenges beyond their control that have kept them from experiencing success in school. Goals will be developed in an effort to evaluate progress. Please note that counseling in a school setting is short-term in nature and solution-focused. If long-term counseling and/or services are needed that are outside the scope of the counseling program, assistance will be given in providing appropriate referrals to one of our mental health therapists or a private or community agency. We look forward to ongoing communication with you.

All information is confidential except in certain situations. The situations are as follows:

- ♦ If your child were to reveal information about harm to others and/or her/himself
- ♦ If your child were to reveal information about child abuse
- ♦ If the counselor's records are requested and/or subpoenaed by the courts

PLEASE SIGN BELOW AFTER READING & AGREEING TO THIS STATEMENT:

By signing this form I give my informed consent for my child to participate in counseling. I understand that:

- ♦ The counseling sessions will provide an opportunity for the student to develop strong interpersonal skills, discuss feelings, share ideas, and/or practice new behaviors.
- ♦ The counselor, except in situations already noted, will keep anything students share in counseling confidential.
- ♦ Anticipated duration of counseling services will begin _____ (date) and end _____ (date).
- ♦ This permission shall remain in effect for 1 year for follow-up sessions past the anticipated dates as needed.

Parent/Guardian _____ Date _____
Signature Print Name

Student _____ Date _____
Signature Print Name

Administrator/Designee _____ Date _____
Signature Print Name

School Counselor _____ Date _____
Signature Print Name

Please call the school counselor, Susana Flores, at Phone # 209-257-5537 for questions and/or comments regarding these services.