

**Los Angeles Unified School District
School Mental Health Services**

Parent/Legal Guardian Consent Form

Name of Student: _____ Date of Birth: _____

Address: _____

Home Phone#: _____ Work/Mobile Phone#: _____

Parent/Legal Guardian Name: _____

I/we have read and understand the services offered at _____

I/we understand further that the services authorized by my/our signature on this form could include the following:

- Psychological mental health and behavioral assessments
- Individual, family, and group counseling
- Home-based assessments/visits
- Mental Health consultation to teachers, administrators and staff
- Crisis intervention and threat assessment
- Collaboration with community agencies and organizations
- Health education

I/we hereby authorized a social worker to provide necessary and/or advisable treatment for my son/daughter. This student has my/our permission to receive all services offered at the AC²T site.

This consent form is valid for the duration that the student is enrolled in _____ AC²T.

Signature of Parent/Legal Guardian: _____ Date: _____

Student's Signature: _____ Date: _____