PERMISSION FOR SCHOOL COUNSELING

Child's Name_____

Age_____ Grade_____

Parent/ Guardian _____

Address_____

Phone_____ Cell _____

Person Referring_____

Reason for School Counseling:

Previous Counseling: Yes _____ No_____ Date(s)_____

Items of concern:

__ self – esteem	__ Poor Study Habits	__Depression
__ anger management	__School difficulties	__ Grief/ Loss of loved one
__ anxiety	__ bullied by others	__ Abuse (Physical)
__ social anxiety	__ bullies others	__ Abuse (Sexual)
__ Adjusting to school life	__ Witnessed Domestic Violence	__ Witnessed Neighborhood Violence
__ Divorce	__ADHD	__ Conflict with Adults

Your signature implies that your child can be seen for school counseling for one year from the date signed.

_____ _____

Parent Signature Date

I look forward to working on your concerns together! Amy Spurgeon MSW, LCSW