Dear SFLS Parent/Guardian,

Sioux Falls Lutheran School (SFLS) has partnered with Carroll Institute (CI) for more than a decade to provide counseling services to our classrooms, small groups, and individual students. Our CI counselor, Mrs. Barb DeVos, has been an important part of the SFLS community since 2009. She is a National Certified Counselor (NCC), Licensed Addiction Counselor (LAC), Licensed Professional Counselor (LPC), and Qualified Mental Health Professional (QMHP). Barb's extensive credentials allow her to provide invaluable services to our students, families, and community members. These services include, but are not limited to: prevention education, social media education, classroom guidance, intervention, support services, individual sessions, small group sessions, and referrals to outside professionals.

This form contains important information for Mrs. DeVos to know about your child's situation. If you desire to have your child participate in individual or small group counseling sessions, please complete this form, in its entirety, and return it to the school office.

Additionally, if your child receives community-based counseling, psychology or psychiatry services, this consent form also contains a release of information authorizing Mrs. DeVos, and/or the school principals, to contact those professionals, as needed, to best support your child's needs by providing coordinated care.

Please note that all licensed counselors are mandatory reporters, therefore, if your child reports self-harm, harm to others, abuse or neglect, this information will be shared with the appropriate authorities, regardless of consent.

By signing this form, you are accepting services from the Counselor employed by CI and contracted with SFLS. If a referral for services is made outside the CI Counselor, please understand that additional documentation may be required to secure those services.

_____Yes, my child (and family) accepts services from Carroll Institute and authorizes the coordination of services with other behavioral health entities.

_____No, my child and family do not accept services from Carroll Institute or authorize the coordination of services with other behavioral health entities.

Child's Name _____ Grade _____

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____Date_____

PLEASE COMPLETE PAGE 2 FOR PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian Contact Information

Date: _____

Student Name: _____

Address: _____

Age: _____ Date of Birth: _____ Gender: _____

Living Arrangements: _____

Student Cell Phone Number: _____

School: _____Grade: _____

Student Employment/Extra-curricular Activities/Hobbies: _____

_____

_____

Parent/Guardian Name(s): _____

Address: _____

Parent Contact information: Email: _____

Phone: _____

PLEASE COMPLETE PAGE 3 FOR COMMUNITY-BASED COUNSELING, BEHAVIORAL, SOCIAL WORK, PSYCHOLOGY OR PSYCHIATRY SERVICES CONTACT INFORMATION

If your child is receiving services from a community-based counselor, behavioral specialist, social worker, psychologist, and/or a psychiatrist, please describe the purpose for utilizing those resources as well as the goals to be achieved:

_____

_____

Please provide us with contact information for any community-based services described above (complete for each specialist involved with your child's care):

Service Provider/Organization Name:_____

Specialist's Name (specific person treating your child):_____

Address: _____

Phone #:_____

Email:_____

****

Service Provider/Organization Name:_____

Specialist's Name (specific person treating your child):_____

Address: _____

Phone #:_____

Email:_____

****

Service Provider/Organization Name:_____

Specialist's Name (specific person treating your child):_____

Address: _____

Phone #:_____

Email:_____