



3629 Church Street  
Covington, KY 41015

Dear Parent or Guardian,

The counseling program in this school offers services to children whose parents refer them. Typical reasons for a referral include concerns about a child’s social skills, mood (for instance, unhappy or apathetic), maturity level, or difficulties at home, (for instance constant uncooperative or negative behavior.) All counselors are employees of Catholic Charities, which contracts with the school to provide counseling services.

If you wish to refer your child to the program, please return the permission slip at the bottom of the page. I will try to see your child as soon as possible, but since a number of children are usually referred for assessment, it may take a few weeks. If your child needs help urgently, please call and let me know so that I can make your child a priority (859-581-8974).

**When I receive the permission slip, the “Rights and Responsibilities” form and the “General Consent” form from you (see attached),** I will call you so that we can discuss your concerns about your child. Meanwhile, I will have the teacher fill out a referral form so I can compare in-school and at-home behaviors. I will also talk with the teacher to get a better idea of how your child is doing in class.

My visits with your child will be 20-30 minutes in length, at a time that the teacher feels will be least disruptive. It may take up to four visits for me to get to know your child well enough to make a recommendation, and since I am not at the school daily, this process may take up to four to six weeks. During this time I may call you to share my insights and recommendations and to discuss any further concerns.

I am eager to work with the teachers and principal to make the school environment as supportive as possible for each child’s emotional health. I may need to share important information about your child or the family situation directly with his/her teacher and/or principal, if it relates to the child’s classroom performance and behavior. This information will be kept in strict confidence.

I hope this information is helpful. **Please sign the attached permission slip, general consent and rights and responsibilities forms and mail them in the enclosed envelope to me at Catholic Charities (address on envelope), or return them to the school office as soon as possible.**

Sincerely,

School Counselor

I grant permission to our school’s counselor from Catholic Charities to meet with and assess my child or my children on school premises during the school day. I also grant permission to the counselor to review my child/ren’s school records and to obtain any information relating to my child/ren from his/her teacher or principal. I have read, and understand, the Client Rights and Responsibilities (**on the other side**), regarding this service.

**\*\*If you would like more than one child to be seen by the school counselor, please list all their names below.\*\***

|                                 |        |
|---------------------------------|--------|
| _____                           | _____  |
| Child and/or Children’s Name(s) | School |
| _____                           | _____  |
| Parent’s Name (Printed)         | Date   |
| _____                           | _____  |
| Parent’s Signature              | Case # |



## School Counseling Program

**Please fill out this form if you would like the School Counselor to see your child.**

School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

County of Birth \_\_\_\_\_ State of Birth \_\_\_\_\_

Parents'/Guardian's Names: \_\_\_\_\_ Parent's Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ home/work (circle) Evening Phone: \_\_\_\_\_ home/work (circle)

Parents'/Guardian's E-mail address: \_\_\_\_\_

Child lives with:  Mother,  Father,  Step-parent,  Legal guardian,  Relative,  Other \_\_\_\_\_

Type of Custody:  Full,  Joint,  Temporary Household Income:  under \$30,000  \$30,000 or over

If joint, please list name and phone number of joint parent: \_\_\_\_\_

Is your child involved with any other agencies? Please check all that apply:

Mental health counselor/psychologist/psychiatrist,  Case worker,  Other \_\_\_\_\_

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1 Have there been any significant changes in your family situation in the last year? Please explain.

2. How does your child relate to parents and siblings? How does your child relate to peers?

3. What are your child's strengths?

4 How does your child perform academically?

5 Does your child have any medical or mental health conditions? Please list any medications your child takes regularly.

6. On the back, please write a few sentences about why you would like your child to see the school counselor.

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PLEASE SEND THIS FORM TO THE SCHOOL ALONG WITH THE SIGNED PERMISSION FORM AND GENERAL CONSENT FORM. THANKS!

If you would like to receive parenting tips via email, please check here \_\_\_\_\_

If you would like to meet individually with a CC parenting educator, please check here. \_\_\_\_\_

Case # \_\_\_\_\_



**General Consent**

Completion of this form verifies that:

**I HAVE BEEN GIVEN A COPY OF CATHOLIC CHARITIES’ “NOTICE OF PRIVACY PRACTICES” AND A COPY OF “CLIENT RIGHTS & RESPONSIBILITIES”.**

I consent to the use and disclosure of information protected by the Privacy Rule of the Health Insurance Privacy and Accountability Act (HIPAA) of 1996 for the purpose of providing services, obtaining payment for services rendered, and/or to conduct normal agency operations as stated in the *Notice of Privacy Practices* and *Clients Rights & Responsibilities*.

**I understand that the services that I will receive while a client of Catholic Charities (CC) are contingent upon my signature on this consent document.**

I understand that I have a right to request a restriction as to how CC uses or discloses protected information to carry out service, payment, and operations. I understand that the agency is not required to agree to the restrictions I may request. However if the agency agrees to the request in writing the restriction will be binding until I agree for the restriction to be removed.

**Areas for Restriction of Protected Information**

- 1. CC may                      may not                      contact me by telephone at home  
Number(s) authorized \_\_\_\_\_
- 2. CC may                      may not                      contact me by telephone at work  
Number(s) authorized \_\_\_\_\_
- 3. CC may                      may not                      contact me by cellular phone  
Number(s) authorized \_\_\_\_\_
- 4. CC may                      may not                      contact me by FAX  
Number(s) authorized \_\_\_\_\_
- 5. CC may                      may not                      contact me by mail  
address(s) authorized \_\_\_\_\_
- 6. CC may                      may not                      contact me by email  
address(s) authorized \_\_\_\_\_
- 7. CC may                      may not                      inform others if and when I am present in the building  
*If CC may share the above information, with whom may it be shared?:* \_\_\_\_\_
- 8. CC may                      may not                      contact me about new program opportunities.
- 9. CC may                      may not                      contact me with news about the agency.
- 10. CC may                      may not                      contact me for opportunities to become a donor.

11. Other requests for restrictions \_\_\_\_\_

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Authorized Personal Representative \_\_\_\_\_  
*(if applicable)*

Relationship to Client      Parent                      Legal Guardian                      Other \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Agency Representative Signature \_\_\_\_\_

*(only necessary to affirm restrictions indicated above)*