



PARENT PERMISSION FOR BEHAVIOR CONSULTANT SERVICES

STUDENT: _____ BIRTH DATE: _____

GRADE: _____ SCHOOL: _____ TEACHER: _____

TEACHER EMAIL ADDRESS: _____

SPECIAL EDUCATION IDENTIFIED: (*Circle one*) YES NO In Process

Eligibility Category(s) _____ 504 PLAN: (*Circle one*) YES NO

REFERRED BY: _____ DATE: _____

PARENT NAME: _____

PARENT ADDRESS: _____

Phone: _____ Cell: _____ e-mail: _____

This is to inform you that your child is being referred for student support services to enhance educational success. The referral was made for the following reasons: (**Please be specific.**)

I authorize the use of Student Support Services for the following purposes:

(PARENT – Please initial next to each authorized service.)

- _____ Review of student records
- _____ Consultation and coordinated services with parent(s), school personnel and/or youth
- _____ Classroom observation, behavior assessment, behavior planning
- _____ Counseling individual and/or group
- _____ Functional Behavior Assessment/Behavior Support Plan

If it is determined that your child is in need of additional services, you will be contacted for your written permission. A written record of these services will be placed in your child’s school records. You have rights regarding your child’s school records, such as the right to review or amend the records and receive copies. The record will be maintained for five years after the school year in which the record was created. After that time the record will be destroyed, unless a parental request is made to retain the record. **This permission form is valid for one year from date of signature, unless specified.**

Please sign here:

Permission is given for services. _____ (parent/guardian signature) _____ (date)

Permission for services is denied. _____ (parent/guardian signature) _____ (date)

Authorized District Signature (if applicable) _____