



# SAINT LOUIS COUNSELING

IMPROVING LIVES SINCE 1955

## SCHOOL PARTNERSHIP PROGRAM (SPP)

9200 Watson Rd., G-101  
St. Louis, MO 63126-1528  
P: 314.544.3800 F: 314.843.0552

(rev 5-1-18)

### Consent Form: Parent/Guardian

**Note: Please read and sign both sections.**

I give permission for my child \_\_\_\_\_

to participate in counseling services with Saint Louis Counseling' school counselor.

Counseling services will be provided at \_\_\_\_\_ School.

Parent/Guardian's Name (Please Print) \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

\_\_\_\_\_

Best Time to Contact: \_\_\_\_\_

Today's Date: \_\_\_\_\_

\*\*\*\*\*

I give permission for the therapist to speak with and/or write to the principal, or other referring school personnel for the purpose of sharing information that will help the school staff understand and work with my child. This consent will remain in effect until counseling is terminated.

Parent/Guardian's Signature \_\_\_\_\_

Today's Date \_\_\_\_\_

Some case records may be used for auditing purposes. All records will be kept in strictest confidence, however.

