

**Davis School District**  
**Safe Schools Clinical Team**  
**Permission For Services**

I give permission for the Safe Schools Clinical Team to conduct a behavior/educational evaluation of my son/daughter, including, but not limited to, those areas listed in Utah Code Ann. §53E-9-203 Student Privacy. The results will be shared (sent and received) with the Clinical Team staff. **Summary notes and considerations will then be discussed at the Davis School District Case Management Team with local school team in attendance.** The Educational Family Resource Facilitator and/or Integrative Educational Therapist may also be involved in helping to either provide limited counseling sessions or connect families with resources and communicate with local teams. These summaries are not full reports, nor school district recommendations. They are meant for consideration by school personnel. Signing this form indicates you have been offered a copy of Utah Code Ann. §53E-9-203 Student Privacy, that you waive the two week waiting period, and give permission for the staff and behavioral health consultants to conduct the evaluation in the areas they determine appropriate. In most cases you have the option to seek an evaluation at your own expense from another appropriately trained professional or agency. This is not a Special Education Evaluation. However, selected results may be shared with the school Special Education, and/or Case Management Teams and they should be contacted if there are question about special education. You may need to sign a release of information to have reports sent to other agencies or individuals. It is requested that you receive testing results feedback by contacting the professional who conducted the evaluation. You have a right to review results and correct factual errors. Your signature indicates that you have read the above, and that the following have been discussed with you:

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|--|---|
| <input type="checkbox"/> Reason for evaluation                       | <input type="checkbox"/> Limited Confidentiality            |
| <input type="checkbox"/> General Types of test/Clinical Interview    | <input type="checkbox"/> Privacy notice/Two week wait       |
| <input type="checkbox"/> Disclosure & use of results/Parent Feedback | <input type="checkbox"/> Refusal right/Alternate Evaluation |

Student Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_  
**Parent/Guardian Signature**                      **Student Signature (If 18 Y/O +)**                      **Today's Date**

Comments: