CONEWAGO VALLEY
SCHOOL DISTRICT

Pioneers in Educational Excellence

Welcome to the K-6th grade Student Assistance Program (SAP),

This program was developed by the state of Pennsylvania over thirty years ago to detect and assist students who may be struggling academically, emotionally, or behaviorally. The program spread from Pennsylvania and is currently offered in many public schools across forty-eight states. The program aids in areas of social and emotional issues, detecting struggles which may be impeding the student's ability to succeed in education. The process is successful due to the team effort of the school and community agencies which combine the school's resources and those of the outside agencies and come together to offer all possible areas of assistance to the family. The program works inside the public school system to detect issues and offer aid in helping families get the outside services needed to again make the student successful in the educational process.

How SAP K-6 works:
A student could be referred to the SAP team in a variety of ways including teacher or administration referral, issues at home from parents, and changes in behavior or grades. Sometimes within the process, the family may request for an assessment which is administered by the community liaison from True North Wellness. This assessment will be conducted with the student and further information will be gathered which required releases to be signed to coordinate the efforts of the agency and the school. Following the assessment and the signatures to release the information to the interested parties, there will be impressions and recommendations which will be offered as a way to aid the student and family in the best course of action to help the student again become successful. These recommendations may be done through the phone contact or written form depending on the ability to contact the recipients.

Following an Assessment:
The student will continue to be monitored by the team and sometimes the outside SAP counselor through ongoing sessions to ensure success or revisit the needs, goals, or even setbacks of the student to further benefit the priority which is a successfully completed elementary education. If there are ever any questions regarding this program, the school counselors can be contacted at each elementary school building.

NOE Counselor: Eric Bowden 717-624-2157 x 7009
CTE Counselor: Lisa Miller 717-624-2157 x 8009
CVIS Counselors: Abby Reichart (4th) 717-624-2157 x 4010
Bitsy Sanders (5th) 717-624-2157 x 4011

Becky Wildasin (6th) 717-624-2157 x 4009

Thank you for your interest in the SAP program and for allowing us to better serve your student!

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Conewago Valley School District Permission To Release Student Information

Date: _____

Child's Name _____ Date of Birth: _____

Parent/Guardian: _____

Home Phone #: _____

Work Phone #: _____ *May we call work:* YES NO
(Circle One)

~~School Attended by Student:~~

CVIS _____

~~Middle School~~ _____

High School _____

I agree to allow my student to meet with the Student Assistance Program Counselor for a maximum of three sessions to complete an assessment process and to receive further individual counseling if advised with the SAP counselor employed through TrueNorth Wellness Services.

Signature of Legal Guardian/Parent: _____

Date: _____

· 130 Berlin Road New Oxford, PA 17350 · 717-624-2157 · Fax: 717-624-5020 ·

TRUE NORTH WELLNESS SERVICES

____625 West Elm Avenue
Hanover, PA 17331

____33 Frederick Street
Hanover, PA 17331

____44 South Franklin Street
Gettysburg, PA 17325

____1195 Roosevelt Ave.
York, PA 17404

____73 E. Forrest Ave., Box 12
Shrewsbury, PA 17361

____5 Pendyrus Street
Delta, PA 17314

____5351 C Jayce Ave., Suite I
Harrisburg PA 17112

____25 State Avenue
Carlisle, PA 17013

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

I, _____, do hereby authorize

True North Wellness Services
To Release To:

Conewago Valley Intermediate School
175 700 Road
New Oxford Pa 17350

True North Wellness Services
To Obtain From:

Conewago Valley Intermediate School
175 700 Road
New Oxford Pa 17350

Information from the record of _____, born _____, SSN ___-___-____.

The specific and relevant type of information I wish to have released is: *(Each item must be checked or crossed out.)*

_____ Admission & Discharge Summaries
_____ Psychiatric Evaluation
_____ Goals / Treatment Plan
__X__ Impressions / Recommendations
__X__ Psychological Reports
__X__ Academic, Attendance, & Discipline Records
_____ Summary of Treatment
__X__ Other: Data collected by the SAP team
_____ Other: _____

The purpose for obtaining these records is:

_____ Coordinating treatment services
_____ Satisfying legal requirements
__X__ Completion of SAP Mental Health Assessment
_____ Other: _____

I understand that this release is valid from _____ to _____ (one year maximum). This authorization is subject to my written or verbal (in person) revocation at any time, except to the extent that the program, which is to make the disclosure, has already taken action in reliance on it. I have been informed of the type of information being released, the benefits and disadvantages (if any), and I understand that treatment services are not contingent upon my decision concerning the signing of this release. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I have read all the above and understand the nature of this release. I understand that I may see a copy of the information asked for in this form. *Initial one:*

I have accepted a copy of the form _____ Initials

I have rejected a copy of the form _____ Initials

_____ Signature of Client/Guardian

_____ Date

_____ Signature of Witness

_____ Date

If any person physically unable to provide a signature desires to consent to this release, print his/her name on the appropriate signature line above and record below the signatures of (2) responsible persons who witness that such person understands the nature of this release and freely gave his/her consent.

_____ Witness of Person Unable to Sign

_____ Date

_____ Witness of Person Unable to Sign

_____ Date

This information has been disclosed to you from records whose CONFIDENTIALITY is protected by Federal and State law. Pennsylvania State Regulations prohibit you from making any further disclosure of this information without the prior written consent of the person in respect to it pertains.

Elementary Student Assistance Program (ESAP)
Student and Family Information

Student Name: _____ D.O.B. _____

Grade: _____ Teacher: _____

Address: _____

_____

Phone Numbers: _____ (home) _____ (cell)

Name and relation of adult male in household: _____

Name and relation of adult female in household: _____

Name of father and mother if they do not reside with the child:

_____

Address: _____

Phone Number: _____

Please list any significant life stressors affecting your family (examples – recent move, death in family, divorce, job loss, etc.) Feel free to list any information you feel would be helpful to know when working with your child.

_____

_____

_____

_____

_____

_____

If separated or divorced, please explain the custody arrangement and visitation schedule for your child.

_____

_____

_____

_____

Childhood Checklist: Which of the following issues concern you or your child? Check those items that apply to your child now.

_____ Crying	_____ Nail biting	_____ Frequent vomiting
_____ Thumb-sucking	_____ Head banging	_____ Chewing odd substances
_____ Allergies	_____ Eating Problems	_____ Stuttering
_____ Lying	_____ Stealing	_____ Nightmares
_____ Sleep walking	_____ Truancy	_____ Other Sleep Disturbances
_____ Trouble with Police	_____ School refusal	_____ Trouble with Authority Figure
_____ Phobias	_____ Fears	_____ Fire Setting
_____ Anxiety States	_____ Masturbation	_____ Bed wetting after age 3
_____ Shyness	_____ Extreme Goodness	_____ Fighting and Quarreling
_____ Sexual Activity	_____ Sexual Identity Issues	_____ Distorted Body Image
_____ Disobedience	_____ Poor school grades	_____ Withdrawn from friends
_____ Back Talking	_____ Drug/Alcohol Usage	_____ Sadness or Depression
_____ Acne	_____ Soiling after age 3	_____ Chronic Constipation
_____ Chronic Diarrhea	_____ Temper Tantrums	_____ Poor self esteem
_____ Tics or Twitches	_____ Ritualistic, repetitive behaviors or preoccupations	

_____ Other: _____

_____

Additional Comments:

_____

_____

_____

_____

_____

_____ _____

Signature of Parent/Guardian Date

Please return this information to me, _____, at your earliest convenience. Please feel free to call me at extension _____ if you have any questions. Thank you.