

## COUNSELING CONSENT FORM

I give permission for my child to receive counseling support from the school psychologist in an individual or group setting. I understand that the services provided will assist my child function more appropriately in school, and that the services will address issues or behaviors that arise within the school setting only. If services and treatment are needed that go beyond the scope of school counseling, the school psychologist will inform me.

Furthermore, I understand that information disclosed by my child within counseling session(s) is confidential. Information will only be shared if the counselor believes that my child may be in danger, as school employees are mandated reporters.

If you have any questions, please contact Aaron Porianda, Director of Special Services.

I have read and understand the above statement.

\_\_\_\_\_  
Parent/Guardian Name (Print)

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Parent/Guardian Name Signature

\_\_\_\_\_  
Date

### CUSD Site Psychologist & Contact Info

<a href="#">Nadia Gil-Williams</a>	<a href="#">Aaron Porianda</a>	<a href="#">Cort Neilson</a>
Coolidge High School	Heartland Ranch Elementary	West Elementary
Coolidge Junior High School	(520) 723 – 2061	Mini Bears Pre-School
Coolidge Alternative Program		(520) 723 – 2730
Coolidge Virtual Academy		
(520) 723 – 2320		