



# Derry Township School District

Administrative Office • 30A East Granada Avenue • P.O. Box 898 • Hershey, PA 17033  
Phone (717) 534-2501 • Fax (717) 533-4357 • www.hershey.k12.pa.us

## PARENTAL PERMISSION FOR CHILD TO PARTICIPATE IN THE STUDENT ASSISTANCE PROGRAM (SAP)

Your child has been referred to the Student Assistant Program (SAP). The Student Assistance Program (SAP) consists of school and community staff that can help your child access school and community resources. The program was developed to help students overcome barriers to success including social, emotional, and relational issues like anxiety, grief, depression, and drugs and/or alcohol use. The SAP team will help you find services and assistance in the school or in the community if needed. The team helps provide you with information to help your child succeed as well as give your child additional support within the school setting.

If the SAP team believes your child could benefit from an informal mental health or drug and alcohol assessment, one can be conducted by a consultant/specialist with your written permission. Upon completion of the informal assessment, the consultant/specialist will contact you to offer recommendations for you to consider. The consultant/specialist does not provide counseling or treatment. The assessment is free of charge and will take place during the school day at your child's school. Any Student Assistance information will be maintained in the strictest confidence.

Please sign below giving permission for your child \_\_\_\_\_ to meet with the applicable representative.

### Check all that apply:

- I give permission for my child to **participate in the Student Assistance Program** of Derry Township School District. I permit the SAP Team to release relevant information from my child's records for the purpose of assessment.
- I give permission for my child to have an **informal mental health assessment** with Keystone Human Services (if applicable).
- I give permission for my child to have an **informal drug & alcohol assessment** with Dauphin County Drug & Alcohol (if applicable).
- I give permission for DTSD to release to/receive from **Community Service Group** for the purposes of making a referral for **School Based Outpatient Therapy**.

Name of Insurance: \_\_\_\_\_

Insurance Number: \_\_\_\_\_

Secondary Insurance name/number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Student (14 years of age or older)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\* According to PA State Law, a student the age of 14 or older has a right to decide how much information is shared and with whom after the assessment.

- I am NOT interested in this program at this time. Please sign below.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date