



**ST. MARTIN PARISH SCHOOL BOARD (SMPSB)  
PARENTAL REQUEST/ACKNOWLEDGMENTS/CONSENT  
MEDICALLY NECESSARY BEHAVIORAL HEALTH PROVIDER SERVICES  
DURING THE SCHOOL DAY**

Date: \_\_\_\_\_

<p><b>Delivered via:</b> ___ U.S. Mail ___ <b>In Person To:</b> _____ <b>Other:</b> _____</p> <p><b>Parent/Guardian/Educational Rights Holder:</b> _____</p> <p><b>Address:</b> _____ _____ _____</p> <p><b>Home/Work Phone:</b> _____ <b>Cell Phone:</b> _____</p> <p><b>Student Name:</b> _____ <b>DOB:</b> _____</p>
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This is a formal request, pursuant to La. R.S. 17:173 and 3996(B)(45) for *(Print full name and address of individual behavioral health provider or provider agency)* \_\_\_\_\_

to provide medically necessary behavioral health services to my child while **at school during the school day**. In making this request:

- G I understand that: (1) this request; (2) a signed Consent to Release Information form; and (3) a copy of a valid behavioral health evaluation completed by a qualified behavioral health provider (BHP) **must be submitted to** \_\_\_\_\_ (Name), **representative of the** \_\_\_\_\_ **Parish School Board** (\_\_\_PSB), **at** \_\_\_\_\_ (LOCATION OR EMAIL ADDR.).
- G I understand that the qualified BHP I have selected must meet additional requirements required by law and \_\_\_PSB policies and procedures in order to access my child for medically necessary behavioral health services during the school day.
- G I understand that the \_\_\_PSB staff will review my request and make a final determination about whether my chosen BHP has met necessary requirements established by law and \_\_\_PSB policies and procedures, including appropriate licensing, insurance, and background check.
- G I understand that incomplete applications for the requested BHP services will not be

considered for approval by the \_\_PSB.

G I understand that I am responsible for any and all costs associated with the medically necessary behavioral health services I have unilaterally selected for my child pursuant to this request.

G I understand that State law requires each student in grades 1-12 to receive a *minimum of **360 minutes of educational instruction***, per day, for a minimum total equivalent of 177 days per school year. (Instructional time consists of scheduled time during the school day devoted to teaching core educational content and educational courses and experiences outlined in a program of studies approved by the Louisiana Department of Education (LDE)).

G I understand that the \_\_PSB provides its students with the required minimum of 360 minutes of educational instruction per day in accordance with State law and LDE requirements.

G I understand that while on a school campus, the behavioral health provider is required by law to comply with, and abide by, the terms of any Individualized Education Program, Individualized Accommodation Plan, Section 504 Plan, Behavior Management Plan, or Individualized Health Plan applicable to a student.

G As a result of my request for medically necessary behavioral health services, I hereby acknowledge and understand that my child **may not** receive the daily educational instruction time to which he is entitled by law and considered by the Louisiana Legislature and LDE to be necessary to facilitate student progress.

G I acknowledge and understand that my child's educational performance may decline or fail to progress due to repeated absences from class and/or occasions of tardiness during the school day as a result of my decision to allow medically necessary behavioral health services during my child's instructional day.

G I understand that, separate from this request, the \_\_PSB offers and makes available certain behavioral health services to identified students who demonstrate an educational need for such supportive services during the school day.

G I hereby decline educationally related behavioral health services made available by the \_\_PSB in favor of the parentally-selected behavioral health services provided by a parentally selected behavioral health service provider paid at my own expense.

G I understand that the BHP's access and services to my child on \_\_PSB premises must conform to parameters established by the Superintendent and \_\_\_\_\_ Parish School Board. Violations are subject to termination and sanctions for a period of two years.

## **REQUEST AND CONSENT FOR BEHAVIORAL HEALTH TREATMENT OF MINOR**

**I CERTIFY THAT I UNDERSTAND THE REQUIREMENTS FOR OBTAINING OUTSIDE MEDICALLY NECESSARY BEHAVIORAL HEALTH SERVICES FOR MY CHILD WHILE AT SCHOOL DURING THE SCHOOL DAY. RECOGNIZING THE POTENTIAL NEGATIVE IMPACT ON MY CHILD'S EDUCATIONAL PERFORMANCE, I HEREBY REQUEST AND AUTHORIZE THE ABOVE-REFERENCED BEHAVIORAL HEALTH PROVIDER/AGENCY TO PROVIDE MEDICALLY NECESSARY BEHAVIORAL HEALTH SERVICES TO MY CHILD, \_\_\_\_\_, WHILE AT SCHOOL DURING THE SCHOOL DAY.**



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**Parent/Guardian/Authorized Representative (PRINTED)**

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**Parent/Guardian/Authorized Representative (SIGNATURE)**

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**Date**