**The School District of Escambia County**
**J. E. HALL EDUCATIONAL SERVICES CENTER**
**30 East Texar Drive**
**Pensacola, FL. 32503, PH. 850/432-6121**

# PARENT CONSENT FOR GROUP COUNSELING SERVICES

| Student Information: **(To be completed by School Personnel)** | | | | |
|---|---|---|---|---|
| School Counselor: | School Counselor Email: | | | |
| Student Name: | DOB: | Student ID#: | | |
| Student's School: | Grade: | Gender: | Race: | |
| Student's Street Address: | City: | | State: | Zip: |
| Referral Reason: | | | | |

| Parent Information: **(To be completed by Parent/Guardian)** | |
|---|---|
| Parent/Guardian Name: | |
| Relationship to Student (Parent, Guardian, Other-Please Explain): | |
| Parent/Guardian Phone: | Student Lives With: |

I authorize_____(School Name) to exchange information with:

☐ Escambia County School District, Mental Health Services

I further authorize the counselor to review school records, to consult with school staff, and to meet with my student to coordinate and deliver services.

_____ _____
Signature of Parent/ Guardian Date

_____
Printed Name of Parent/Guardian