ACT

A chance to talk…

SCHOOL COUNSELING

PARENT/GUARDIAN CONSENT/PERMISSION FORM

IMMACULATE CONCEPTION SCHOOL

Name of child(ren):_____DOB_____

_____DOB_____

_____DOB_____

I hereby _____give _____do not give permission for my child(ren) to receive counseling services with Karen Lundy, Licensed Clinical Professional Counselor, a joint effort between Karen Lundy and Immaculate Conception School, to assist children, families, and schools in improving academic, emotional, behavioral, and social development and competence.

If you choose not to give consent, your child will not be eligible to be seen by the counselor. You may choose to withdraw this consent at any time by putting the request in writing. Thank you.

_____ _____

Signature of Parent/Guardian Date