St. Lucie PUBLIC SCHOOLS
Each Child, Every Day

Division of Student Services
9461 Brandywine Lane
Port St. Lucie, FL 34986
Office (772) 429-4510
Fax (772) 429-4589

Parent Permission for Counseling

Student Name:		ID#										
School:	Teacher/Team:		Grade:		DOB:							

Your child has been referred for counseling services at their school. The counseling will occur during the school day and will include:

___Individual Counseling
___Group Counseling

Services will be provided by: _____

If you consent to these services, please sign below, and return to the school. You may revoke your consent at any time. Your consent will remain active for the remainder of the current school year unless you indicate otherwise.

Please feel free to contact me at _____, if you have any questions.

Parent/Guardian/Student 18 years or older, must complete the following:

I give permission for the counseling of my child.

_____	_____
Signature of Parent/Guardian/Adult Student	Date Signed