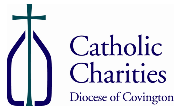


3629 Church Street
Covington, KY 41015

Dear Parent or Guardian,

Your student has been referred to the Catholic Charities school based counseling program. Referral can be made by the student themselves, teacher, principal, or by a parent/guardian. Typical reasons for referral include concerns with social skills, mood (for instance, unhappy, anxious, or apathetic), maturity level, or behaviors that are disruptive at home or school. All counselors are employees of Catholic Charities, are licensed, and have contracts with the school to provide counseling services. If you wish for your child/ren to work with the school counselor, **you must sign and return this form.** Other than crisis and emergency referrals, the counselor cannot continue services until this form is received. The counselor will see your child as soon as possible but there can be waiting lists. If your child needs help urgently, please contact your school counselor directly.

Visits with your child will be 30-45 minutes in length, at a time that is mutually agreeable between the counselor and school. Once your child has been seen four to six times the counselor will contact you to discuss goal planning and insights. You may contact the counselor at anytime. Counselors work with the teachers and principal to make sure the school environment is as supportive as possible for each child's emotional health. They may need to share important information about your child or the family situation directly with his/her teacher and/or principal, if it relates to the child's classroom performance and behavior.

My signature below grants PERMISSION/CONSENT to the following items: 1) for the school's counselor from Catholic Charities to meet with and assess my child/ren on school premises during the school day, 2) the counselor to review my child/ren's school records, previous Catholic Charities school counseling records 3) to obtain any information relating to my child/ren from his/her teacher or principal 4) to contact me by the ways indicated below 5) I have read, and understand, the Client Rights and Responsibilities (**on the other side**).
Optional: During unplanned school closures, I agree to telehealth services (only during normal school calendar days, not summer or scheduled days off) ☐ YES ☐ NO

Please sign this permission/consent form in blue or black ink, list child/ren names, read the Rights and Responsibilities, and fill out the parent info form. Return them in the enclosed envelope to me at Catholic Charities (address on envelope), or return them to the school office as soon as possible.

I wish to be contacted by Provider in the following manner (please check all areas that would be an acceptable manner to contact you);

- ☐ Home ____________________
- ☐ Cell ______________________
- ☐ Work _____________________
- ☐ Student Cell phone(optional)__________________
- ☐ Provider may leave a message with person answering numbers above or leave name, number, & message on voice mail for numbers above

Please check how you would like information sent to you:
☐ Email:_________________________________
☐ Mail: _________________________________
(Please list complete address above)

If joint custody, please list name, email, phone of joint parent/guardian):

____

Other services your child is involved with:____

Print Name of Authorized Parent/Guardian (if under 18)________________________________

Relationship to Client ☐ Parent ☐ Legal Guardian ☐ Other______________________________

Parent/Guardian Signature ____Date_________

CC Worker Signature ____Date_________

Turn Over To Read Client Rights and Responsibilities

 Case # ___________

CLIENT RIGHTS AND RESPONSIBILITIES

Because of our interest assisting you in meeting your needs, and protecting your privacy under the Health Insurance Portability and Accountability Act of 1996, we have identified what we consider to be your essential rights in making use of our services, as well as equally important responsibilities which will make it possible for you to fully benefit from the particular service environment in which you will be participating. These rights and responsibilities are listed here and in the attached Notice of Privacy Practices for your information. You will be asked to read and sign this notice of Client's Rights & Responsibilities as well as a General Consent which allows Catholic Charities to share certain aspects of your protected health information for treatment, billing and health care operations. Your understanding of and signature on these two documents will be necessary prior to the provision of services.

RIGHTS

√ ***The right to know***
You have the right to know about and understand as completely as possible the intended results and effects, both positive and negative, of any kind of professional service in which you participate. As professional human service providers, we are strongly committed to an approach in which our clients are seen as partners in a learning, healing, and growing endeavor. We make a consistent effort to develop a service plan with you which is responsive to your needs in a direct, open, and collaborative manner. We also encourage you to ask questions about what you experience or to voice any concerns you have about the professional approaches we may use in moving toward the solutions you seek.

√ ***The right to confidentiality***
Since the focus of our work together involves areas of your life that can be very sensitive and personal, we are totally committed to serving you in a manner which respects your rights to privacy and confidentiality. We cannot disclose any information that you have given us in using the services which we offer without your permission. We will only share information with other outside professionals or receive records of your work with them if we have your written consent.

There are, however, legally mandated exceptions to this policy, one of which involves disclosure concerning abuse and neglect. As human service professionals, we are required by law and ethical mandate to report a reasonable suspicion of abuse or neglect to appropriate legal jurisdictions. In addition we are required to report our concerns should we suspect self-harm might come to a person with whom we are assisting, or that that person may harm another.

√ ***Graduate Internships***
Catholic Charities is a training facility engaging graduate interns who bring with them the latest in helping technologies from accredited programs at the colleges and universities in our area. An intern may be assigned as your service provider. Should an intern be assigned as your service provider you will be informed.

√ ***The right to safe environment***
Catholic Charities is committed to maintaining a safe environment in which all individuals (staff, service recipients, volunteers and vendors) are treated with respect and dignity. Catholic Charities prohibits the use of restrictive behavior management interventions or any other practice that provides isolation, locked seclusion, manual or mechanical restraint, and/or chemical restraint to all clients including minors.

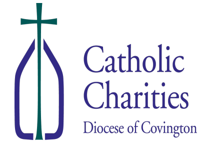
√ ***The right to complain***
If you are dissatisfied with your treatment or the services you receive, you have the right to contact the Executive Director and file a formal complaint. Should you choose to do so, you need to simply write or call the Executive Director. We treat these complaints very seriously and make every effort to resolve them in a just and fair manner.

√ ***The right to refuse or terminate service***
Since the professional services which we offer are voluntary in nature, you have the right to say no to any recommendations or approaches that are offered to you. In addition, you also have the right to decide how long you want to make use of our services and to terminate that service. (See below: *Termination of Services)*

RESPONSIBILITIES

√ ***Termination of Services***
If you decide to terminate service, we ask that you make this known directly to your service provider. While we respect your right to terminate services, ending can be an important step, so we encourage you to talk this decision over with your service provider. Discussing this decision can be an opportunity for mutual learning.

School Counseling Client Information Page



This information is kept confidential. If your child was seen last year please check below and complete <u>only</u> if there have been any changes in the below information.

☐ **My child/ren was/were seen last year.**

Child's Name: ______________________ School: _______________Teacher: ________________

Grade: ______ DOB: _______________ State & County of birth: ________________________________

Address: ____ City: ______________ Zip Code: _________

Parents'/Guardian's Names: ____

Occupation: ______________________________ Parent's Date of Birth: ____________________

Household Income (Please check one): □10,000-14,999 □15,000-19,999 □20,000-29,999 □30,000-39,999

□40,000-49,999 □50,000-59,999 □60,000-69,999 □70,000-79,999 □80,000-89,999 □90,000 or over

Medical Insurance provider: ______________________________ Primary Dr.: ____________________

☐ Case worker:________________, ☐ Counselor/psychologist/psychiatrist: _______________________

**To adhere to best practice in the delivery of mental health services a release of information may be requested to speak with these professionals.*

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1. Have there been any significant changes in your family situation recently? (moves, divorce, separation/custody change, new school, death/serious illness) Please explain:

2. Has anything happened to your family or your child that has caused distress? If yes please explain

3. List who lives in the home and how does your child relate to them?

4. How does your child relate to peers?

5. What are your child's strengths?

6. How does your child perform academically? (grades, does not work to potential, learning challenges)
Comments:

7. Does your child have any medical or mental health conditions/diagnosis? Please list any medications your child takes regularly.

8. Is there a family history of medical/mental health /substance abuse? Yes _____ No _____
Please explain:

9. Please check any of the following that apply to your child:

_____	Sleep disturbance (can't fall asleep, up too early, up at night)	_____	Fearful of new people/places/school	_____	Cries easily, often
_____	Oppositional: complying with bedtime, house rules, refusal to go to school, other	_____	Easily distracted/fails to finish things	_____	Feelings easily hurt
_____	Complains of body aches	_____	Daydreams	_____	Bullies others
_____	Bowel/urinary problems	_____	Impulsive behaviors (acts before thinking)	_____	Regressive behaviors: baby talk, whining/constant reassurance, sucks/chews on things
_____	Appetite concerns	_____	Always on the go/restless/squirmy	_____	Speech difficulty
_____	Behavior Problems	_____	Disturbs others	_____	Let's self be pushed around
_____	Problem making/keeping Friends	_____	Irritable/quarrelsome	_____	Frequently tells lies/stories that are untrue
_____	Worries more than others	_____	Destructive/steals	______	Substance use (specify below)

Please offer further explanation to any checked items and what you would like to see change for your child: