Student Services/Exceptional Student Education

Referral for Mental Health Counseling Services Form

Student Name:____ Date:____________________

Date of Birth:________________ School:______________________________ Grade:______________

Your student is being recommended for counseling services. In order to decrease barriers to counseling, Alachua County Public Schools can refer your student to one of our contracted mental health agencies to provide counseling at school. Assisting our students with their mental health can help them manage their feelings and learn positive ways of coping with life situations. When students are mentally healthy, it has positive effects on their academic achievement. Our goal is to provide your student with the mental health care needed so they can feel good about learning, themselves and their future.

Once a student is referred to one of our contracted mental health partners an assessment and treatment plan will be completed by the therapist. Your student's counseling services (duration and frequency) will be determined by the treatment plan and will not exceed the current academic school year.

As part of the counseling process, it is important for parents/guardians to be in communication with the contracted therapist and school counselor. It will be required that you participate in an intake meeting with the therapist before counseling can start.

Please check one:

☐ ***I have read the above information and hereby give my consent for my child to be referred to an ACPS contracted mental health partner for counseling services. By signing I am consenting to release information to the ACPS mental health partnering agency that will provide counseling to my student. I understand that I can revoke my consent at any time.***

☐ ***I choose to decline a referral for counseling services for my child at this time. I understand that I may request counseling services at a later date if needed***

Parent/Guardian Signature:_____________________________________ Date:____________________

Counselor Signature:____ Date:____________________

☐ ***Consent was given over the phone***

Parent Name:____ Phone Number:_________________

Counselor Signature:______________________________________ Date:__________________________

If you have any additional questions or concerns please contact:
Dr. Toni Griffin or Kimberly Joy at 352-955-7671, ext.1670.

For District Office Use:

Mental Health Services ID#____________________________________

MHS Referral for Counseling Form
January 2019

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Approval Signature of ACPS Representative *Date*

Form No.: STU-920-002 - Referral for Mental Health Counseling Services Form / SS-General
Revised Date: 5/19/22