Derry Township School District
Homestead Road, Hershey, PA 17033

PARENTAL PERMISSION FOR CHILD TO PARTICIPATE IN THE HERSHEY INTERVENTION & PREVENTION PROGRAM

I/We, _____, ☐ do ☐ do not grant permission for my/our child,
(Name of Parent or Guardian)

_____, to participate in the Hershey Intervention

& Prevention Program of the Derry Township School District.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of Child Date

I/We, _____, ☐ do ☐ do not grant permission for my/our child,
(Name of Parent or Guardian)

_____, to meet with ad hoc members of the HIP Team from the **Keystone Human Services** and /or **Dauphin County Department of Drug & Alcohol Services.** I/We permit the HIP Team to release relevant information from his/her school records for the purpose of assessment. All information will be handled and maintained in the strictest confidence.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of Child Date

*Your child will benefit from your immediate response.

KEYSTONE
HUMAN SERVICES
"Advancing the Human Spirit"

Your child has been referred to The Student Assistance Program (SAP) at his/her school. In the event that the SAP team feels your child could benefit from an informal mental health assessment one will be conducted by the mental health consultant with your written permission. Upon completion of the informal assessment, the mental health consultant will contact you to offer recommendations for you to consider.* The mental health consultant *does not* provide counseling or mental health treatment. **In order for the assessment to take place Keystone needs your written permission below.**

The assessment is free of charge and will take place during the school day at your child's school. Any Student Assistance information will be maintained in the strictest confidence.

Thank you for your cooperation.

*According to PA law, a student the age of 14 or older has a right to decide how much information is shared and with whom after the assessment.

KEYSTONE HUMAN SERVICES
Student Assistance Program – Informal Mental Health Assessment
PARENT PERMISSION FORM

I give my permission for my son/daughter_____
(Name)

to meet with a mental health consultant from Keystone Human Services, Student Assistance Program in order to participate in an informal mental health assessment.

_____
Parent/Guardian Printed Name

_____ _____
Parent/Guardian Signature Date