DeSales Catholic School

Permission Slip for School Counseling Services

Dear Parent/Guardian:

Your child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, has been referred to the school-counseling program for assistance in the following area:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Your child will be seen in an individual setting during regular school hours. In order for services to be provided, your permission is needed. If you agree to allow your child to participate in the counseling program at DeSales Catholic School, please complete the form below, detach and return it to school with your child as soon as possible.

Please note that counseling in an educational setting is short term in nature and solution-focused. If long-term counseling and/or services are needed that are outside the scope of practice of the DeSales Catholic School counseling program, assistance will be given in providing appropriate referrals to private or community agencies.

Please contact the school counselor if you have any questions or concerns.

Katie Badura

School Counselor of DeSales Catholic School

[badurak@desalescatholicschool.org](mailto:badurak@desalescatholicschool.org)

(716) 433-6422 Ext. 461

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parent/guardian printed name) agree to allow my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (child’s full name) to participate in counseling activities for the current academic school year.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_