Greenville Area School District

Student Assistance Program
Parent/Guardian Consent Form

Your child has been referred to the Student Assistance Program (SAP). This voluntary program is available to offer supportive services to students experiencing academic, behavioral, and/or emotional difficulties that may pose barriers to school success. Students can be referred by parents/guardians, school personnel, peers, or self-referrals.

The SAP team is comprised of specially trained teachers, administrators, school counselors, and behavioral health consultants. Our goal is to work together to offer any supports your child may need. Where barriers are beyond the scope of the school, the team can provide linkage for families to access community resources.

You are a vital part of the team and SAP values the importance of parent/guardian involvement in this process. If you would like the team's assistance and are in agreement to participate in the program, please complete the bottom portion of this section (which must include your signature.)

Student Name: (First, middle, & last) _____

Grade: _____ **Date of Birth:** _____

Parent(s)/Guardian Name: _____

Relationship to child: (_____)

Address: _____

_____

E-Mail: _____

Contact information where you may be reached to discuss your child's referral:

- **Home/Cell Phone:** _____ **Alternate Phone:** _____

__ *Please check if you give consent to receive text messages regarding your child's referral*

_____

Parent/Legal Guardian Signature **Date**

_____

Student Assistance Team Member Signature **Date**

The SAP Team also works in partnership with the Mercer County Behavioral Health Commission, Inc., to provide liaison services to all students and families who may be in need of assistance with coordinating services outside of school. The liaison gathers information and provides consultation to all parties involved in order to assist with making appropriate and necessary linkages to recommended services.

By signing below, I give permission for the liaison to provide assistance with my child's referral. Their assistance may include a brief interview or observation of my child during school hours, if necessary. I also agree to coordinate a date and time to speak with the liaison at the school in order to review & finalize recommendations, make connections to any necessary resources, as well as participate in all phases of the action plan. Thank you.

_____

Parent/Legal Guardian Signature ***Date:***

_____

Student Assistance Team Member Signature ***Date:***

☐ **Please check this box if you DO NOT give permission for your child to proceed with the Student Assistance Program at this time.**