WEST SHORE SCHOOL DISTRICT
STUDENT ASSISTANCE PROGRAM

Parent/Guardian name	*Student name*	*Grade*	*Building*

☐ I DO ☐ I DO NOT

give permission for my child to participate in the Student Assistance Program (SAP). This program's purpose is to identify and assist students who are experiencing barriers to learning. The SAP team is made up of trained school and agency staff. SAP is NOT a treatment program; rather, its objective is to identify at-risk students who may then be referred to in-school supports or community resources.

I have been advised that this program is voluntary and information obtained is confidential.

Date *Signature of Parent/Guardian**

Date *Signature of Student*

☐ I DO ☐ I DO NOT

give permission for my child to meet with a Teenline counselor if recommended by the SAP team. Teenline is a service of Holy Spirit Health System. The Teenline counselor will conduct a mental health assessment to determine recommendations for further support services. If a recommendation for treatment is made, the counselor will discuss options with the parent and student. I permit the SAP team to release relevant information from my child's school records for the purpose of assessment. All information will be maintained in the strictest confidence.

Date *Signature of Parent/Guardian**

Date *Signature of Student*

☐ I DO ☐ I DO NOT

give permission for my child to meet with a counselor from _____ if
Agency name
recommended by the SAP team. The counselor will conduct a drug and alcohol assessment to determine recommendations for further support services. If a recommendation for treatment is made, the counselor will discuss options with the parent and student. I permit the SAP team to release relevant information from my child's school records for the purpose of assessment. All information will be maintained in the strictest confidence.

Date *Signature of Parent/Guardian**

Date *Signature of Student*

***Signature must be of the parent/guardian who has primary physical/custodial care.**