



# Area Special Education Cooperative

1505 Central Ave NW, East Grand Forks, MN 56721  
218/773-0315 FAX: 218/773-0924

## Permission to Counsel

Date \_\_\_\_\_

Dear \_\_\_\_\_

Counseling services from the school psychologist are available to your child on a short term basis, for \_\_\_\_\_ sessions. The school psychologist will meet  *individually* with your child or  *with a small group of students* to discuss \_\_\_\_\_

\_\_\_\_\_. Counseling does not involve a formal assessment and no written report will be filed.

The counseling cannot occur until your written permission is received. You may withdraw your permission at any time and your permission will not go beyond the current school year.

If you have any questions, please call me at the \_\_\_\_\_. I am in your district on the following days: \_\_\_\_\_

<b>Please Check:</b>	<input type="checkbox"/>	I give permission
	<input type="checkbox"/>	I do not give permission
for my child _____ to receive counseling.		

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Daytime Phone Number

Enclosed are two (2) copies. Sign one copy and return it to \_\_\_\_\_.  
The other copy is for your records.

Sincerely,

\_\_\_\_\_  
Licensed School Psychologist

C: Parent