# CONSENT FOR SERVICES

**Mental Health Professional**

|  |  |  |
| --- | --- | --- |
| Student’s Last Name | First Name, MI | Teacher/Grade |
|  |  |  |

Dear Parents or Legal Guardians,

We are seeking your permission for our School Mental Health Professional Lindsay Marquez to provide psychosocial educational group interventions or individual interventions, as identified below.

* Group work:
* Individual work:
* Observation:

Please complete the information below and return it to school with your child indicating that you give permission for their participation in the services identified on this form.

If you have any questions or concerns, please do not hesitate to contact the School Mental Health Professional directly.

Thank you!

Lindsay Marquez, MA, MFT, CPC

School Mental Health Professional

Lindsay.Marquez@washoeschools.net

Email

775-851-5630 ex 30629

Phone number

I give permission for my child, , to receive the services identified on this form from the School Mental Health Professional. Consent for services will be valid for one year.

Permission can be withdrawn at any time with written notice to the School Mental Health Professional.

Parent/Guardian (Print Name) Parent/Guardian (Signature) Phone Number Date

Parent/Guardian (Print Name) Parent/Guardian (Signature) Phone Number Date

*Consent must be provided by all custodial parents or legal guardians.*