Catholic Family Services

www.cfsstl.org

SPP (SCHOOL PARTNERSHIP PROGRAM)

(rev 8/2015)

Consent Form: Parent/Guardian

Note: Please read and sign both sections.

I give permission for my child_____ to participate in counseling services with Catholic Family Services' school counselor.

Counseling will be provided at _____School.

Parent/Guardian's Signature _____

Phone Numbers: _____

_____

Best Time to Contact: _____

Today's Date: _____

I give permission for the therapist to speak with and/or write to the principal, or other referring school personnel for the purpose of sharing information that will help the school staff understand and work with my child. This consent will remain in effect until counseling is terminated.

Parent/Guardian's Signature _____

Today's Date_____

Some case records may be used for auditing purposes. All records will be kept in strictest confidence, however.

9200 Watson Road, G-101
St. Louis, MO 63126-1528
Phone (314)544-3800 ***Fax*** (314)843-0552

(rev 8/2011)

[FOR OFFICE USE ONLY: CASE# SLS_____]

St. Louis County Children's Service Grant

Request Form for School-Based *COUNSELING SERVICES*

Catholic Family Services-School Partnership Program 9200 Watson Road, G101, St. Louis, MO 63126

Office - 314-544-3800 Director – 314-602-6846 Fax - 314-843-0552

DATE OF REFERRAL _____

STUDENT NAME [one student/referral] LAST_____ FIRST_____

ADDRESS_____CITY_____ZIP CODE_____

DOB_____GRADE_____GENDER_____RACE_____HOME PHONE_____

PARENT/GUARDIAN NAME_____WORK PHONE_____

PARENT CELL NUMBER_____PARENT E-MAIL ADDRESS (IF APPLICABLE) _____

PREFERRED CONTACT TIME[S] _____WHO HAS LEGAL CUSTODY, IF DIVORCED_____

DOES THE STUDENT HAVE A CURRENT/PAST IEP? _____IS THE STUDENT CURRENTLY TAKING MEDICATION? _____

DOES THE STUDENT HAVE A KNOWN DIAGNOSIS? _____

SCHOOL_____SCHOOL PHONE NUMBER_____

SCHOOL ADDRESS_____

PRINCIPAL/PERSON REFERRING_____

TEACHER NAME_____TEACHER E-MAIL ADDRESS_____

IS THERAPY A CONDITION FOR STUDENT TO REMAIN IN SCHOOL? YES NO (IF YES, PLEASE GIVE FURTHER EXPLANATION IN COMMENT SECTION BELOW)

ADDITIONAL COMMENTS OR CONCERNS YOU HAVE IN REFERRING THE ABOVE STUDENT (PLEASE ATTACH ADDITIONAL PAGE, IF NECESSARY)

_____

_____

_____

PLEASE HAVE A PARENT OR TEACHER COMPLETE THE PEDIATRIC SYMPTOM CHECKLIST FOUND ON THE REVERSE SIDE BEFORE SENDING REQUEST FORM

Pediatric Symptom Checklist (PSC)

(age 17 and under)

CHILD'S NAME:_____ DATE:_____

COMPLETED BY:_____

RELATIONSHIP TO CHILD:_____

Please complete the following by circling the corresponding number most often observed in the last 60 days

	Rarely	Sometimes	Often
1. Complains of aches or pains	0	1	2
2. Spends more time alone	0	1	2
3. Tires easily, little energy	0	1	2
4. Fidgety, unable to sit still	0	1	2
5. Has trouble with a teacher	0	1	2
6. Less interested in school	0	1	2
7. Acts as if driven by a motor	0	1	2
8. Daydreams too much	0	1	2
9. Distracted easily	0	1	2
10. Is afraid of new situations	0	1	2
11. Feels sad, unhappy	0	1	2
12. Is irritable, angry	0	1	2
13. Feels hopeless	0	1	2
14. Has trouble concentrating	0	1	2
15. Less interest in friends	0	1	2
16. Fights with others	0	1	2
17. Absent from school	0	1	2
18. School performance dropping	0	1	2
19. Is down on him/herself	0	1	2
20. Visits with doctor with nothing found wrong	0	1	2
21. Has trouble sleeping	0	1	2
22. Worries a lot	0	1	2
23. Wants to be with you more than before	0	1	2
24. Feels he/she is bad	0	1	2
25. Takes unnecessary risks	0	1	2
26. Gets hurt frequently	0	1	2
27. Seems to be having less fun	0	1	2
28. Acts younger than children his/her age	0	1	2
29. Does not listen to rules	0	1	2
30. Does not show feelings	0	1	2
31. Does not understand other people's feelings	0	1	2
32. Teases others	0	1	2
33. Blames others for his/her troubles	0	1	2
34. Takes things that do not belong to him/her	0	1	2
35. Refuses to share	0	1	2

***TOTAL SCORE=**	

*For school age children, significance is 28 or higher. For non-school age children, significance is 24 or higher.