



# UMCHS, INC.

## PARENTAL PERMISSION FOR MENTAL HEALTH CONSULTATION

I give permission for UMCHS Mental Health Consultants to gather information about my child (name) \_\_\_\_\_ to assist in developing and providing planned activities and supports in the classroom that will foster positive social-emotional development. This may include reviewing her/his UMCHS file, consulting with UMCHS staff, asking UMCHS staff to gather information on her/his classroom functioning, asking parents and staff to complete social-emotional assessment inventories, and observing her/him in the classroom. I understand the Mental Health Consultants will be Mental Health Professionals on staff or with an agency that UMCHS has an interagency agreement.

If the Mental Health Professionals recommend developing an Individualized Prosocial Guidance plan for her/him in the classroom, I will be invited to participate in its development.

If the Mental Health Professionals feel that he/she could benefit from Mental Health Treatment Services they will meet with me to discuss a possible referral. A referral by UMCHS for Mental Health Treatment Services can only be made with my written permission.

I understand that all information collected by the Mental Health Consultants will be kept confidential and can only be released with my written permission.

\_\_\_\_\_  
**Child's Name** (Please Print)

\_\_\_\_\_  
**Parent's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Parent's Name**

\_\_\_\_\_  
**Staff's Signature**

\_\_\_\_\_  
**Date**

I want to set up a meeting with the Mental Health Consultants to discuss the information gathered.  Yes \_\_\_ Initial  
 No \_\_\_ Initial