CONSENT FORM FOR SCHOOL PSYCHOLOGY SERVICES

This personal information or personal health information is being collected under the authority of Beautiful Plains School Division and will be used for educational purposes or to ensure the health and safety of the student. It is protected by the Protection of Privacy provisions of the Freedom of Information and Protection of Privacy Act (FIPPA) and the Personal Health Information Act (PHIA). If you have any questions about the collection, contact the Beautiful Plains School Division office at 204-476-2387.

Student:	School:
Grade:	Teacher:
Date of Birth (day/month/year):	
Parents/Guardians:	
Address:	Phone Number(s):

Service(s) recommended by the Student Services Team:

☐ (Ongoing) Consultation

_____ _____
Signature of Parent(s)/Guardian(s) ***Date***

☐ Intervention/Counselling ☐Group ☐Individual

_____ _____
Signature of Parent(s)/Guardian(s) ***Date***

☐ Assessment **In the case of an assessment, please also complete the **School Information Form**.**
☐Psycho-Educational ☐ Behavioural ☐Adaptive ☐Other: _____

_____ _____
Signature of Parent(s)/Guardian(s) ***Date***

Parent(s)/Guardian(s) please complete:

☐ I/we_____ consent to _____ receiving the above
Parent(s)/Guardian(s) Child
service(s). I understand that the School Psychologist may do some observations, testing, intervention, and/or consulting with my child. I understand that information obtained will be discussed with the school team and may be used to inform my child's programming. I understand that information about the referral, and in the case of an assessment, a written report, will be placed in my child's pupil support file.

Signature of School Psychologist: _____ Date: _____

Signature of Principal: _____ Date: _____