Diablo Vista Elementary School
4791 Prewett Ranch Drive – Antioch, CA 94531
Counselor: Ms. Joy Yan – **PH:** (925)779-7470
Email: joyyan@antiochschools.net

Consent to School Counseling Services

To the Parents/Guardians of _____,

Your child has been invited to participate in the Diablo Vista School Counseling Program.

Provisions of Service

Counseling services take place during regular school hours and will be provided by the school counselor free of charge. Your child may be seen in a group, in individual sessions, for periodical check-in's and/or a combination of those listed weekly, monthly, or as needed. He or she will participate in a number of activities related to counseling in possible areas such as academic, social, emotional, and behavioral goals as they relate to school.

It is understood that this service is NOT intended to be long-term intensive mental health therapy, nor is it a substitute for psychological counseling, diagnosis, or medication.

Confidentiality

To build trust, information shared by your child is confidential with the exceptions as required by law that include: evidence that your child is in danger of harming him/herself or someone else, your child is being harmed by an individual, threats to school security, if ordered by the court, and or if there is intent to commit significant property damage.

In the rare case, the counselor *may share limited* information with parents/guardians, the child's teacher, administrators, and/or school personnel who work with the child only on a ***need to know basis*** to serve in the best interest of student and to better assist the child as a team.

If you would like the counselor to share information with a third party, such as a therapist, outside community counselor, social/case worker, or pediatrician, an additional release of information form will need to be completed.

In order for counseling services to be provided, your permission is needed. If you agree to allow your child to participate in the counseling services at the school, please print and sign your name below and return both pages of the form to the school as soon as possible.

Please note, a signed permission slip does not automatically guarantee or warrant regular services.

Additional information can be found on our website at https://www.antiochschools.net/o/dves/page/our-counselor,or by contacting the school counselor.

Student Information

Child's Full Name: _____ **Grade:** _____

Date of Birth (mm/dd/yy): _____

Parent/Legal Guardian Information

Parent/Legal Guardian Printed Name: _____

Relationship to the Child: _____

Address: _____

_____

Phone: _____

Email: _____

By signing below, I agree to allow my child to participate in weekly counseling sessions and or counseling related activities with the school counselor for the current academic school year. I have read, understood, and agree to the terms of this consent. If at any point I decide that I no longer want my child to receive these services, I will let the school and the counselor know by providing a written letter to the school.

Parent/Guardian Signature: _____ **Date:** _____

CYBHI Information & Support

If you have completed this information at the beginning of school registration, you may skip this portion of the form.

AUSD is participating in California's Children and Youth Behavioral Health Initiative (CYBHI). This program funds and maintains essential mental health services for all students. If consent is granted and the appropriate information (insurance number and policy number) is provided, you allow the district to be reimbursed by providers for these services at no cost to you. All information is handled confidentially and protected under federal privacy laws. *You will never be charged for the services your student receives, there is no co-pay, and it will not impact the deductibles or existing benefits that you currently have in any way.*

More details can be found at https://cybhi.chhs.ca.gov/ or by contacting the school counselor directly.

Choosing not to participate in the CYBHI program will not impact counseling services that can be provided, granted that the permission has been signed and given above.

Medical Insurance Provider: _____

Child's Member ID Number: _____

By signing below, I agree to allow AUSD to bill my insurance via the California Youth Behavioral Health Initiative (CYBHI) for qualifying mental health services rendered to my student. I understand that this will be at no cost to me and does not impact my deductibles or existing benefits in any way.

Parent/Guardian Signature: _____ **Date:** _____