R.E.A.C.H.
Reaching Educational Achievements with Clinical Mental Health
Located at Conemaugh Township Area Middle School/High School
300 West Campus Ave
Davidsville, PA 15928

PARENT/GUARDIAN CONSENT
Active for the 2025-2026 School Year

Child's Name:		
DOB:	Grade:	Homeroom Teacher:
Parent/Guardian Email:		Parent/Guardian Email #2:
Parent/Guardian Cell: ( ) - -		Parent/Guardian Cell #2: ( ) - -

It is a policy of Conemaugh Township Area School District and R.E.A.C.H. to gain consent from parents to be able to provide mental health services to children under the age of 18 years. R.E.A.C.H. will obtain both parents written consent for children under the age of 14 (if parents do not reside together). Custody agreements may be needed/requested.

This is a referral based service. You, your child, or concerned teacher can make this referral. Parents will be contacted by the R.E.A.C.H. Counselor prior to meeting with your child. If an emergency or crisis situation occurs, you will be contacted after the safety of your child and others is ensured.

This is a confidential and voluntary service.

I am signing to acknowledge that I am giving my consent as biological parent/guardian to allow him/her to receive mental health services through Conemaugh Township Area School District from R.E.A.C.H. I have received information about the type of services provided by R.E.A.C.H. and voluntarily consent to R.E.A.C.H. and the level of care recommended. I am aware that I am able to contact the office at any time to inquire about mental health services and receive updates.

By signing as a student, I acknowledge and agree to the services provided for school-based counseling and voluntarily commit to being an active participant in the counseling process.

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature Date

Initial below to indicate your reason for signing this consent:
Parents/Guardian will be contacted prior to any change in services for your child.

_____ I consent for my child to receive Individual Counseling or Social Work Services

_____ I consent for my child to participate in Small Group Counseling