Conemaugh Township Area School District
R.E.A.C.H.
(*Reaching Educational Achievements with Clinical Mental Health)*
Parent/Guardian Consent

Conemaugh Township Area School District - Mental Health Services
Active for the 2024-2025 School Year

Child's Name: _____

Child's Date of Birth: _____Child's Homeroom Teacher/Grade_____

Parent/Guardian Contact (*Best way to contact)*:_____

_____

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. This is a referral based service. You, your child, or concerned teacher can make this referral. This is a confidential and voluntary service.

- I am signing to acknowledge that I am giving my consent as biological parent or guardian, to allow him/her to receive mental health services through Conemaugh Township Area School District from R.E.A.C.H.
- 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.
- I am aware that I am able to contact the office at any time to inquire about mental health services and receive updates.
- 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.

_____ _____ _____
Parent or Guardian Signature Date Relationship to Student

_____ _____ _____
Parent/Guardian Signature Date Relationship to Student
(2nd Parent signature if both parents do not live in the same household)

Check 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

R.E.A.C.H.
School-based services details

Intake Process

Parents/Guardians will be contacted to provide Intake information to the Clinician (History, current needs, goals). Please express any concerns and information at this time. Parents/Guardians may be able to attend the Intake in person, virtually, or via phone. At this time, your child's Clinician will inform you of the counseling process and what to expect.

Duplication of Services Agreement

School-based clinical counseling and behavioral counseling services are a professional service. Please notify your child's counselor of any/all mental health or behavioral health services in place. If your child receives services from multiple providers we need signed releases to work as a team! If similar services are in place, we will discuss which service best meets your child's needs.

Cancellation/no-show policy

It is a policy of R.E.A.C.H. to provide consistent counseling services for your child to receive the highest standard of care. Every attempt will be made to create a schedule that fits your child's needs. A 24 hour notice is required to cancel an appointment and can be done through a phone call or email. After 3 cancellations without 24 hour notice or 3 missed appointments the clinician will discharge your child from services. We will review this policy for each instance of missed appointments to remind you and your child of the importance of keeping scheduled appointments.

_____ _____
Client Name/Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date

R. 5/23/23