Holy Spirit School

PARENTAL CONSENT/PERMISSION FORM

Name of Child(ren): _____

Teacher: _____ Grade: _____

I hereby authorize permission for my child(ren) to receive counseling from Sheila Mays, LCSW. The Holy Spirit counseling program is an initiative of the Archdiocese of Louisville that links families and school systems in the interest of children's academic and social success. The counseling relationship is confidential except where disclosure is legally required.
These situations include:

1. When the counselor becomes aware of danger or harm to self or another person
2. Any suspicion or evidence of abuse or neglect
3. Compliance with a court order
4. When the client requests and signs a release of information

_____ _____
Signature of Participant Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

☐ Check this box if there are no current concerns, and you would like this form put on file for possible future use.

☐ Check this box if there is a current concern for your child(ren) and you would like the counselor to contact you now.

** *Please note: This permission form must be completed, signed and returned to the school before any counseling can begin. Upon receiving the form, the counselor will call you to gain background information and discuss any concerns you may have. I look forward to working with you and your child.*