

Oley Valley Middle School
3247 Friedensburg Road
Oley, PA 19547

P.A.S.S. Team
Pupil Assistance Support System

I acknowledge that _____ has been referred to the Oley Valley Middle School P.A.S.S. Team and that an integrated behavioral health assessment is being offered to my child.

I understand that a credentialed Student Assistance Program professional counselor, contracted to receive state Student Assistance Program funding, will perform the integrated assessment at no cost to me. The integrated behavioral health assessment is designed to determine the need for any or additional counseling services. The professional counselor will make their recommendations, if any, for type/frequency of private counseling and provide resources to you. At that time it is your decision if you wish to pursue the recommendations.

The assessment takes approximately forty-five minutes and would be conducted during the school day. As part of the assessment, your child may be asked a variety of questions to screen for a number of concerns.

I hereby authorize the assigned SAP certified professional counselor to conduct an integrated assessment. I understand that the results and recommendations of the assessment are confidential and will only be shared with myself.

I am in agreement with the integrated behavioral health screening.

Parent/Guardian Name

Parent/Guardian Signature

Date

I am **NOT** in agreement with the integrated behavioral health screening.

Parent/Guardian Name

Parent/Guardian Signature

Date

SAP Team Member Signature

Date