MENTAL HEALTH CONSULTATION FORM

I, ____________________________________, give my permission to the Sequatchie Valley (Parent/Guardian) Head Start Program Mental Health Provider __________________________________ to: (Provider’s Name)

(check all that apply)

_____ observe my child, _______________________________ in the classroom. (Child’s Name)

_____ discuss with me (parent) about my current concerns.

_____ to provide classroom consultation regarding my child.

A report will be written by the Mental Health Provider and filed under lock and key with the Mental Health Coordinator. The report will be confidential and only the parent(s), the Provider, and the Coordinator will have access to said report.

______________________________________  _________________________
Parent/Guardian Signature                Date

______________________________________  _________________________
Provider’s Signature                 Date