

Baltimore County Public Schools
Office of Psychological Services
9610 Pulaski Park Drive, Suite 219
Baltimore, MD 21220

Parent/Guardian Permission for Consultation/Counseling Intervention

Date: _____

Student: _____ School: _____

Date of Birth: _____ Grade: _____

Your child has been referred for consultation or short-term counseling intervention to address concerns regarding learning and/or behavior.

The school psychologist will meet with your child in individual or group sessions, and consult with school staff. These contacts are confidential. Written reports of these intervention services will not be maintained in your child's school records. If you wish to have a written or oral report sent to school personnel or to a professional outside the school system, your written permission will be required.

School Psychologist: _____

Telephone: _____

I hereby authorize consultation or short-term counseling intervention for my child.

Parent/Legal Guardian: _____

Date: _____