DEER LAKES SCHOOL DISTRICT
STUDENT ASSISTANCE PROGRAM
163 EAST UNION ROAD
CHESWICK, PA 15024
PHONE: (724) 265-5300, ext 2673

S.A.P. Parent Permission Form 2022-2023

Student's Name: ______________________________ Date of Birth: _________ School: ______________

Grade: ________ Homeroom: ___________ Family Phone Number: ______________________________

Your child, ____________________, has been referred to the Student Assistance Program (SAP). This voluntary program is available to offer supportive services to students experiencing academic, behavioral, and/or emotional difficulties that may pose barriers to school success.

Students can be referred to the SAP by parents/guardians, school personnel, peers or self-referrals. The SAP team is composed of specially trained teachers, administrators, school counselors and a mental health and/or drug/alcohol consultant. Our goal is to work with you and to offer support and recommendations for your child. Where barriers are beyond the scope of the school, the team can provide information so families may access community resources.

You are a vital part of the team and the SAP team values the importance of parent/ guardian involvement in this process. A team member is ready to talk with you about the referral and obtain information about your child.

Please complete the bottom portion of this letter and return it to your child's school counselor. If you have any questions, please call School Counselor Mrs. Jenn Barnes at 724-265-5340, ext. 5670 Thank you for being part of our team.

______ I give permission for my child to participate in the Deer Lakes School District Student Assistance Program (SAP) (please check all that apply).

______ Continuation of support services from previous year

______ Group participation Monitoring of behavior and/or academic performance

______ Behavioral Health Services / Referrals _______ Other:_____________________________

Screenings can be conducted by a DLSD mental health liaison or a mental health liaison from Holy Family. Please check below who you would like to complete your child's screening. If you choose to utilize Holy Family, please sign BACK/ATTACHED sheet.

_______A confidential screening conducted by the SAP mental health liaison from DLSD or

_______A confidential screening conducted by the SAP mental health liaison from Holy Family Institute during school hours at my child's school building.

_______ I do not give permission for my child to participate in SAP. I understand that should I change my mind, I can contact anyone on the SAP Team.

Parent/Guardian Name and Signature: ___________________________________Date: ___________

This permission is good for the 2022-2023 school year and may be revoked, in writing, at any time.

8235 Ohio River Boulevard
Pittsburgh, PA 15202-1454
412.766.4030
www.hfi-pgh.org

Student Assistance Program (SAP)
Screening Agreement/Consent

A free screening is being offered to your child at Deer Lakes East Union Intermediate Center by Holy Family Institute. Your permission is necessary for the screening to take place. Please fill in the information below. If you do not want your child to be screened, please check the appropriate line below and sign.

Amy Di Gennaro will be the SAP Liaison conducting the screening. She can be reached at (412) 807-8323 or DiGennaro.Amy@hfi-pgh.org should you have any questions regarding this screening.

Please note that:

- All information obtained for the screening is strictly confidential and not part of your child's school record.
- Your participation and input in this process is highly valued.
- Any report of suicidal intent, threat to physically harm others or suspected child abuse does not require consent to share information with the proper authorities.

I, ____ (print name)

_____ **GIVE MY PERMISSION**_____ **DO NOT GIVE MY PERMISSION**

for the SAP Liaison from Holy Family Institute to conduct a screening with my child, ________________________ for the purpose of offering recommendation of services that may be of assistance to my child.

____

DATE SIGNATURE OF PARENT/GUARDIAN

____

DATE SIGNATURE OF STUDENT (14 YRS OR OLDER)

____

PHONE EMAIL ADDRESS BEST TIME TO BE REACHED

I, ____ (print name)

_____ **GIVE MY PERMISSION**_____ **DO NOT GIVE MY PERMISSION**

For Holy Family Institute to share the recommendations of the screening with the school district.

____

DATE SIGNATURE OF PARENT/GUARDIAN

____

DATE SIGNATURE OF STUDENT