**[School or Agency Letterhead]**

**Student Assistance Program (SAP)**

*Agencies/schools using this document should carefully review the sample document below to compare with their policies and procedures regarding release of information. This document is meant to be customized to align with your policies and procedures.*

You have previously given permission for your child, (insert student name) , to participate in the SAP process. Based on the information gathered, your child is being referred for the screening indicated below, to gather additional information on their behavioral health needs so that we can better support your child.

\_\_\_\_\_ Drug and Alcohol Screening

\_\_\_\_\_ Mental Health Screening

\_\_\_\_\_ Combined Drug and Alcohol/ Mental Health Screening

For additional information, contact (insert name) at (insert contact information).

Choose one of the options below:

\_\_\_\_\_\_ I give permission for my child to participate in a confidential screening conducted by the \_\_(agency name)\_\_ SAP Liaison during school hours at my child’s school building. I understand that this screening is conducted as part of the SAP process and the recommendations may be shared with the SAP Team.  This will allow the SAP team to make appropriate referrals to in-school and out of school supports for my child.  This information will also be shared with me.   I can request to review the screening tool that will be used with my child.

\_\_\_\_\_\_\_ I do not give permission for my child to participate in a screening conducted by the (agency name) SAP Liaison. I understand should I change my mind, I can contact (appropriate contact) .

Parent/Guardian Name:

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_