**[School Letterhead]**

**Student Assistance Program**

**Initial Parent/Guardian Consent Template**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

Your child, [insert child’s name], has been referred to the Student Assistance Program (SAP) team [or insert your team’s name] at our school. This voluntary program is available to offer supportive services to students experiencing academic, behavioral, social, and/or emotional difficulties that may affect their success in school.

The SAP team [or insert your team’s name] is made up of trained school staff and staff from [Insert name (s) of your County funded liaison agency]. Our team members are: [List names and position of each school team member, for liaisons list their agency]. Our goal is to work with you and your child to offer support and recommendations to address any concerns.

The SAP [or insert your team’s name] team values parent/guardian involvement in this process. With your permission, our team will collaborate with you and your child and gather direct input that will help us to better understand your child’s strengths and needs. We will work together with you to make appropriate recommendations.

Please complete the information below and return it to the school by [insert date]. If you have any questions about the Student Assistance Program, please contact [insert the name of the SAP team member], at [insert contact name and/or phone number]. Thank you.

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Please check one of the following options below:

\_\_\_\_\_\_ I give permission for my child, [insert child name], to be involved in the SAP [or insert your team’s name] process and for a member of the team to meet with my child.

\_\_\_\_\_\_ I do not give permission for my child to proceed with the SAP [or insert your team's name] process.

Parent(s)/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_