



**DISTRICT SCHOOL BOARD OF PASCO COUNTY
DEPARTMENT OF STUDENT SERVICES
CONSENT FOR STUDENT SERVICES ASSISTANCE**

MIS Form #420
Rev. 1/11

To the Parents or Guardians of _____ Parent Contact Date _____

School _____ Grade _____ Student Number _____ DOB _____

Parent Information:

Address _____ Home Phone _____

City _____ Zip _____ Work Phone _____

From _____

_____ has requested that additional information be gathered in order to develop strategies and/or to provide services to assist your child.

School staff that may work with your child include:

_____ School Counselor _____ School Psychologist _____ Other _____

_____ School Nurse _____ School Social Worker _____

Areas of Concern _____

Procedures Recommended (e.g., Screening, Threat Assessment, Counseling, etc.) _____

You will be included and informed of results and recommendations throughout this process.

Signature of Staff Member Title Date

Parent or Guardian Consent	
Check One: _____ Permission is given for service	
_____ Permission is denied for service	
_____ I request a conference to discuss this matter	
_____ Parent or Guardian Signature	_____ Date
This consent is valid for the remainder of the current school year and may be rescinded at any time. This consultation may result in a written report.	