



Statement of Consent

Student's Name (Last): _____ (First): _____

Birthdate (mm, dd, yyyy): _____

Parent/Guardian (s): _____

Phone (home): _____ Phone (work): _____ Other: _____

Email Address: _____

I agree to the provision of counseling services for my child and/or family by Community Support Worker, Denise VanDomselaar.

YES NO (please circle one)

I authorize the release of information to relevant educational and/or medical personnel on the above named student for the purpose of providing support for my child/family.

YES NO (please circle one)

Consent is provided for the current school year, unless it is withdrawn.

YES NO (please circle one)

OR

Consent expires on ____/____/____
M D Y

Please contact Denise at 780-963-0507 if you have questions or require further information.

Parent / Guardian Signature

Date