

**Student Assistance Program (SAP)**

**Screening by a mental health/drug & alcohol liason**

 Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Grade: \_\_\_\_\_\_\_

 Student’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_ I give permission for my son/daughter to participate in a confidential screening conducted by the 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 will be shared with the SAP Team. It will allow the SAP team to make appropriate referrals and necessary linkages to in-school and out-of school supports for my child. This information will also be shared with me.

\_\_\_\_\_\_\_\_\_\_ I do not give permission for my son/daughter to participate in a screening conducted by the SAP liaison. I understand that should I change my mind, I can contact anyone on the SAP team.

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

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