SCHOOL-BASED SERVICES OFFERED IN PARTNERSHIP WITH EXCELSIOR SPRINGS SCHOOL DISTRICT

Student Name: _____ School Name: _____

School-based mental health services are offered to families/students through a partnership between the school district, Tri-County Mental Health Services, and Synergy Services. Educational activities focused on prevention, increasing resilience, self-regulation skills, and strengthening social/emotional development may be offered to your student through school-wide and classroom-based initiatives. However, referral-based services and/or student specific interventions require guardian/parental consent (with the exception of students who have reached the age of 18).

1. _____ **Consent to be contacted via phone, text, or email for referral-based services:** Tri-County Mental Health and Synergy Services offer referral specific services in the form of: individual therapy, family therapy, small group counseling, small group resilience/prevention education, art therapy, music therapy, substance use counseling, case management, and psychiatric services. My initials indicate that I give my consent to have a mental health professional contact me when/if a referral is received to discuss my interest in arranging referral-based services. I understand that email and text messages may not be considered a secure method of transmission. If you do receive an email/text from a Tri-County or Synergy staff member, we will limit the information until we can speak with you over the phone or in person. I understand I may choose to accept or decline services when contacted.

2. _____ **Consent to provide brief, student-specific intervention:** Tri-County Mental Health and Synergy providers are located in specific buildings throughout the school district. At times, students may experience a need for brief intervention/support due to daily events or stressors. My initials indicate that I give consent for a mental health professional to support my student in regulating their emotions, one-on-one and/or in collaboration with a school staff, with the goal of helping them make safe choices and transition back to the classroom. I understand that brief interventions are not considered therapy. I understand that if my student is seen by a Tri-County provider, I will be contacted by the provider and informed about the brief support intervention that occurred. Mental health professionals from Tri-County & Synergy will notify parents/guardians about any plans to check-in further with the student.

Name of Student (please print): _____

Student Date of Birth: _____

Parent/Guardian Name (please print): _____

Phone Number: _____

Email: _____

Parent/Guardian Signature: _____