West Mifflin Area School District

West Mifflin SAP Program Parent/Guardian Consent

Office: 412-466-9131 | Fax: 412-466-4595

Dear Parent/Guardian:

Your child has been referred to our school's Student Assistance Program (SAP).

We are requesting your permission to gather more information about your child through the SAP program. Collection of this information will be done via submission of observations forms from other district staff members who may have direct or indirect contact with your child throughout the school day. The goal of SAP is to work with you and offer supports for your child. SAP helps students overcome barriers so that they may achieve, advance, remain in school, and if there are barriers are beyond the scope of the school, the SAP team can provide information so families may access community resources. The team is comprised of SAP trained teachers, administrators, professional school counselors, and mental health consultants. The SAP program is mandated in the commonwealth of Pennsylvania by Section 1547 of the School Code and 22 Pa. Code 12.42. If you would like more information about the program, please refer to the website: www.education.pa.gov

All information will be kept confidential amongst the SAP coordinator and the SAP team.

If you allow the SAP process to continue for your child, please sign below and return to the district official listed below.

If you should have any questions, please do not hesitate to contact us. Thank you.

Sincerely,

_____

WMASD SAP Parent/Guardian Consent

Student Printed Name:_____ Grade:_____

Parent/Guardian Printed Name:_____

Parent/Guardian Signature:_____ Date:_____

Check one choice below and return it to a member of the SAP Team

_____ YES, I allow the West Mifflin Area School District SAP Team to continue with the SAP process and collect additional information about my child.

_____ NO, I do not allow the West Mifflin Area School District SAP Team to continue with the SAP process and collect additional information about my child.

*Some of the information you provide throughout this packet will be repetitive. Please know that different services are requesting different types the information.

SAP Permission to Evaluate: Data Form

This form will be sent to Devereux: TCV Community Services. A person from this service will contact you by phone to schedule a date to evaluate your child. If your child received services over the summer, there is no need for your child to be evaluated again.

Student Information:

Child's First and Last Name:_____

Child's Date of Birth:_____ Race:_____

Does your child receive special education services? _____

Did your child receive services over the summer? _____

Parent/Guardian Name:_____

Parent/Guardian Phone Number:_____

Health Insurance Information:

Insurance Company Name:_____

Provider ID Number:_____

Group ID Number:_____

Name of the Policy Holder:_____

Devereux
TCV COMMUNITY SERVICES
A Devereux Partnership

School_____

TO: Parent/Guardian _____

Home Address _____

Parent/Guardian Phone Number _____

Parent/Guardian Email Address _____

RE: Student _____ Grade Level _____ Gender M F O

Date of Birth _____Race _____SpecEd/504/Gifted_____

I, (Parent/Guardian) _____, hereby request and authorize **West Mifflin Area School District** and **Devereux TCV Community Services** to release and exchange the following information with regard to my child, _____ for the purpose of conducting behavioral health screening and/or report. **This consent will automatically expire one month after the end of the present 2025/2026 school year.**

Information to be released between school and TCV Community Services:

X Academic/Attendance/Suspension/Detention Records
X Summary of Behavioral Health screening/Education Summary/Follow-up observation
X Shared Verbal information by school/other needs as reported by student

I understand that by law, I need not consent to the release of this information; however, I choose to do so willingly and voluntarily for the purpose specified above. I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFT Part 2 and cannot be disclosed without my written consent unless otherwise provided for in State and Federal regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it.

_____ _____
Student Signature (if applicable) Date Parent/Guardian Signature Date

_____ _____
Witness (School Personnel) Date Witness (Agency Personnel) Date

Reason for SAP Referral: Academic Concerns (please check all that apply)

_____ Grades Declined _____ Truancy _____ Suspension(s) _____ Transfer from another school

_____ Lacks Focus _____Skipping Class _____ Violation of school policy_____

Behavior Concerns (please check all that apply)

_____ Anxiety _____Social Skills _____ Recent changes in behavior ____Recent Hospitalization ___Autism

_____ Fighting _____ Bullied _____ Aggression _____Seeking M/H Services _____ D&A Concerns

_____ Recent death/loss _____ Family Concern _____ Self Harm _____ Suicidal Ideation _____Depression

Please add any additional concerns you have at this time:

_____