Student Assistance Program
Permission to Evaluate

Date:
Student Name:

I understand that my child, _____, has been referred to the Student Assistance Program (SAP) at Park Forest Middle School and that through the Student Assistance Program, I may obtain an assessment of _____'s needs. In addition, I understand that the assessment will be done at school by the Centre County SAP Liaison, Jordan Alexander. Please indicate your decision by signing one of the options below:

1. I grant permission for my child, _____, to receive the mental health / drug and alcohol assessment. I understand that school personnel and the SAP Liaison will exchange information as part of this assessment process.

_____ _____
(Parent Signature) (Date)

2. I DO NOT grant permission for my child to receive the assessment. I understand that school personnel are concerned about my child and are recommending that s/he receive the assessment.

_____ _____
(Parent Signature) (Date)