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**Parent/Guardian Informed Consent - Services –**

**Olathe Public Schools’ Help Clinic**

Dear Parent/Guardian:

Your student has been recommended for services through the Olathe Public Schools’ Help Clinic. The Help Clinic provides a variety of services centered around improving student learning through better mental health. The service your student has been recommended for is listed below:

The date this service would begin is\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The service is scheduled to end\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If school is canceled (I.e. snow day), the service your student is receiving may go longer than this date.

You may revoke your consent at any time. Please contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ with any questions.

**I understand and give informed consent for my student, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to participate and receive the above described service(s).**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

****Parent/Guardian Name Date