

Dear Parent/Guardian:

Your child _____, has been referred to the Sayre School District Student Assistance Program (SAP). This program provides various confidential support services designed to meet your child's academic, health and human service needs. A team of school personnel and community agency professionals will assess your child's needs and offer to you appropriate recommendations for in-school and/or out-of-school services. Please assist us in aiding your child by signing the consent form below. By signing this consent form I understand that my child will have either a Drug & Alcohol and/or Mental Health assessment. If participation in this school's SAP program does include a drug and alcohol evaluation, and you would like a blank copy of the evaluation questions to be answered by your child, please contact Phil Cusano, Director of Bradford/Sullivan SCA at (570) 265-1760.

After the assessment/evaluation is completed, a recommendation will be shared with the child, parent, and SAP Team.

STUDENT'S NAME _____ GRADE _____

ADDRESS _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

TELEPHONE NUMBER _____

Signature of Parent/Guardian

Signature of Student

Date

Parent's Comments:

Student Assistance Team Members:

Stacy Richmond	Guidance Counselor	Katherine Parks	NHS
Judy Schrader	School Nurse	Matt Poll	SAP D&A
Mary Cole	Teacher	Dayton Handrick	Principal
Michelle Jennings	Teacher		

Please return this form as soon as possible to the Guidance Office.

STUDENT ASSISTANCE PROGRAM PARENT INFORMATION SHEET

Parent/Guardian Name: _____ Date: _____

Student Name: _____ Grade: _____

PLEASE NOTE: THIS SURVEY IS SENT TO ALL PARENT(S)/GUARDIAN(S) OF STUDENTS WHO HAVE BEEN REFERRED TO THE SAP TEAM. ALL QUESTIONS ARE OPTIONAL AND RESPONSES WILL BE SHARED WITH THE SAP TEAM ONLY. THE PURPOSE OF THIS SURVEY IS TO HELP US FURTHER DEFINE ANY DIFFICULTIES YOUR CHILD MAY BE EXPERIENCING IN SCHOOL.

YES NO

___ ___ HAVE YOU OBSERVED ANY BEHAVIORS THAT CONCERN YOU ABOUT YOUR CHILD?

___ ___ DOES YOUR CHILD HAVE ACADEMIC DIFFICULTY?

___ ___ DO YOU HAVE ANY CONCERNS THAT YOUR CHILD MAY BE EXPERIMENTING WITH DRUGS OR ALCOHOL?

___ ___ ARE THERE ANY FAMILY STRESSORS THAT MAY BE AFFECTING YOUR CHILD'S ACADEMIC PERFORMANCE?

DOES YOUR CHILD . . .

___ ___ EXHIBIT HEALTH PROBLEMS?

___ ___ RELATE WELL TO OTHERS?

___ ___ SHOW INTEREST IN CULTS OR GOTH?

___ ___ SHOW INTEREST WITH THEMES OF DEATH?

___ ___ SHOW UNDUE INTEREST IN VIOLENT ACTS?

___ ___ DISCUSS DRUGS/ALCOHOL FREELY?

___ ___ EXPRESS THOUGHTS ABOUT SUICIDE?

___ ___ HAVE FREQUENT MOOD SWINGS?

IF YOU MARKED YES TO ANY OF THE ABOVE, PLEASE PROVIDE FURTHER INFORMATION IN THE SPACE PROVIDED BELOW.
