SAYRE AREA SCHOOL DISTRICT

Aiming for Excellence

Guidance Office

331 West Lockhart Street
Sayre, Pennsylvania 18840

Telephone (570) 888-2190
Fax (570) 882-9385

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 the 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________

TELEPONE NUMBER _________________

________________________ ________________________ ___________

Signature of Parent/Guardian Signature of Student Date

Parent's Comments:

____

Student Assistance Team Members:

Dayton Handrick	Principal	Mary Cole	Teacher
Daniel Polinski	Assistant Principal	Michelle Jennings	Teacher
Stacy Richmond	School Counselor	Wendy Shaw	NHS
Judy Schrader	School Nurse	Lorie Radney	SAP D&A

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

STUDENT ASSISTANCE PROGRAM PARENT INFORMATIION 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.

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STUDENT ASSISTANCE PROGRAM

Mental Health Assessment Agreement

I hereby give permission to conduct a Mental Health Assessment for my child

____, with a Mental Health Liaison from NHS Human Services. The assessment and feedback will be for the SAP team, my child and myself. I understand that the liaison will communicate with me and make appropriate recommendations for assisting my child.

________________________________ ____________________

Parent/ Guardian Signature Date

BRADFORD/SULLIVAN DRUG & ALCOHOL SINGLE COUNTY AUTHORITY

220 Main St., Unit #1, Towanda, PA 18848
570-265-1760 1-800-588-1828 fax: 570-265-8541

Student Assistance Program (SAP)
Drug and Alcohol Screening and/or Assessment

Student's Name: ____

Grade: ____

Student's Date of Birth:____

________I give permission for my son/daughter to participate in a confidential screening and/or assessment (Level of Care Determination) conducted by the Drug and Alcohol SAP Liaison during school hours at my child's school building. I understand that the screening/assessment is conducted as part of the SAP process, however, due to State and Federal confidentiality laws, my child will be required to sign a release of information form. This will allow recommendations to be made to the SAP team to assist them in making appropriate referrals and necessary linkages to in-school or out-of-school supports for my child.

________I do not give permission for my son/daughter to participate in a screening and/or assessment conducted by the Drug and Alcohol SAP Liaison. I understand that should I change my mind, I can contact anyone on the SAP Team.

Parent/Guardian Signature ____

Date: ____

Mailing Address: ____

____

Phone Number:____