



**THIS FORM MUST BE RETURNED**

**Parent Consent Form**

The American Academy of Pediatrics recommends all youth have a yearly emotional screen. *Please complete this form and have your child return it to the school as soon as possible.*

I have read and understand the description of the Christian Family Solutions Screening Program.

<p>_____ I would like my child to participate in the Christian Family Solutions Screening Program.</p> <p>_____ My child has special needs, e.g., physical, verbal, educational, interpreter. Explain:</p>
<p>_____ I do not want my child to participate in the Christian Family Solutions Screening Program because:</p>

**Student's Name (print):** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Student's School:** \_\_\_\_\_

**Student's E-Mail Address:** \_\_\_\_\_

**Parent/Legal Guardian's Name (print):**

\_\_\_\_\_ **Parent/Legal**

**Guardian's Signature:**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent Information**

Please provide the following information so we can contact you with results of the screening:

**Address:** \_\_\_\_\_

\_\_\_\_\_ **Cell #:** \_\_\_\_\_

\_\_\_\_\_ **Home #:** \_\_\_\_\_

**Work #:** \_\_\_\_\_ **Parent E-mail:** \_\_\_\_\_

**Best way to be contacted during school hours:**     Cell     Home     Work     E-mail

**Questions? Contact the screening coordinator:**

Whitney Donovan, LPC, LMHC, NCC, BC-TMH

800.438.1772, ext. 1207 [wdonovan@wlcfs.org](mailto:wdonovan@wlcfs.org)

[Click here for full information about the screening program.](#)