KELLENBERG MEMORIAL

P (516) 292-0200
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Request for School Psychologist Support: Parent-Initiated

Dear Mr. Lyons,

I would like to request that my child be permitted to see the School Psychologist. In making this request, I am authorizing the School Psychologist to meet with my son or daughter during school hours. He/She may speak to teachers, counselors and others significant in the life of my child. I understand that this service is limited and cannot be ongoing in nature.

Student's Name: _____

Student's Grade: _____ Student's Date of Birth: _____

Student's Address:_____

Reason for request:
_____
_____
_____
_____
_____

I give consent for my child to receive counseling services from the School Psychologist.

Printed Name of Parent/Guardian:_____

Relationship to student:_____

PARENT/GUARDIAN SIGNATURE:_____

Date:_____ Parent/Guardian Contact:_____

This consent is valid for a period of one (1) year