

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Record #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT FOR SERVICES**

1. **Consent for Services:** I voluntarily consent that my child will participate in individual and/or groups services with staff from Youth First Inc. The services provided will be conducted by a Masters Level Social Worker supervised by clinically licensed staff. Services will be conducted within the boundaries of Indiana Law for Social Work, Professional Counseling, and/or Marriage and Family Counseling.
2. **Charges:** There are no charges for services provided by Youth First Social Workers.
3. **Confidentiality:** Information about provision of services to my child are contained in a confidential record at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_], I give Youth First permission to share information about the dates, times and general reason why my student is receiving social worker service at their school. The school is permitted to provide information to the social worker about academic and social emotional learning history.
4. **Right to Withdraw Consent:** I have the right to withdraw my consent for services at any time by providing a written request to the Youth First Social Worker.
5. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.
6. **COVID-19 Policy** in Accessing Social Work Services:  It is the policy of Youth First that any student or faculty receiving services inside the Youth First social worker's office will wear a face covering.  If your child is not able to wear a mask, a face shield will be provided.
7. In the event that your child's school closes for any reason, **Teletherapy** may be available. By signing this document, I voluntarily consent that my child will participate in Teletherapy Services with their Youth First Social Worker. The same conditions of confidentiality and right to withdraw services apply to Teletherapy Services.

**I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the services. I understand that I have the right to ask questions of my service provider about the above information at any time.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Parent/Guardian Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of witness Date**

**Cell phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

ם Check this box if you do not wish to be added to the Youth First Mailing list

Revised 10/2016