

**NORTH CENTRAL KANSAS SPECIAL EDUCATION COOPERATIVE**

PARENTAL PERMISSION FOR COUNSELING

(Must be considered for ED students)

I give my permission for my child, \_\_\_\_\_

to be involved in counseling with \_\_\_\_\_,

School Psychologist, a staff member of the North Central Kansas Special Education Cooperative. I understand I may revoke permission at any time.

\_\_\_\_\_ Individual Counseling

\_\_\_\_\_ Group Counseling

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

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I am aware that counseling services with the school psychologist are available for \_\_\_\_\_  
\_\_\_\_\_. However, at this time we request counseling not be initiated.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date