

I give consent to \_\_\_\_\_ to refer my child,  
\_\_\_\_\_ as identified to the Professional Services Group School  
Based Mental Health Clinic. I agree to sign all relevant paperwork and participate in my child's  
treatment as much as possible.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness/Referral Source Signature

\_\_\_\_\_  
Date