Gateway Middle School

Mr. Rocco Telli / Principal

Student Assistance Program (SAP)

____ Drug and Alcohol Screening Consent

____ Mental Health Screening Consent

Student's Name:_____

Grade: _____

Student's Date of Birth:_____

_____ I give permission for my son/ daughter to participate in a confidential screening conducted by the SAP Liaison during school hours at my child's school building. I understand that this screening is conducted as part of the SAP process and the recommendations will be shared with the SAP Team. It will allow the SAP team to make appropriate referrals and necessary linkages to in-school and out-of school supports for my child. This information will also be shared with me. I have the right to request to review the screening toll that will be used with my child.

_____I do not give permission for my son/ daughter to participate in a screening conducted by the SAP Liaison. I understand that should I change my mind, I can contact anyone on the SAP Team.

Parent/ Guardian Signature:_____

Date:_____

Mailing Address:_____

_____

Phone Number:_____