Student Assistance Program

Permission Forms

The Student Assistance Program, better known as SAP, is a peer to peer support group that focuses on building healthy relationships with kids K-12.

We focus on establishing healthy relationships in order to build self-confidence, positive social interactions and promote respect for ourselves and others!

There are 3 sessions: each session is 8 weeks long for approximately 45 minutes and meets once a week after school.

All SAP groups are confidential, protecting the privacy of students.

If you would like your child to participate, please fill out this packet and return to your child's school or drop off at 2126 McCulloch Blvd N, Suite 14, Havasu Community Health Foundation.

THE BENEFITS OF SAP

- *Build friendships*
- *Build healthy relationships*
- *Promote strength and resiliency*
- *Feeling supported and validated*
- *Promote healthy lifestyle*
- *Promote understanding and caring between peers and adults*
- *Reduce feelings of loneliness and the need to isolate*
- *Promote self esteem and confidence*
- *Prevent self harm*
- *Provide healthy coping skills*

For more information or questions please contact the
Student Assistance Program Coordinator, Shyla Perkins
928-453-8190 • shyla.hchf@gmail.com

Student Assistance Program under the umbrella of
Havasu Community Health Foundation a 501c3 Charity Tax ID 20-1839858

Name of Child: _____ DOB: _____

Address: _____ Phone: (_____)_____

Parent/Guardian: _____ E-Mail: _____

Teacher: _____ Grade: _____ School Attending:_____

Parent Signature: _____ Date: _____

Return to Shyla Perkins Student Assistance Program Coordinator • 928-453-8190 • shyla.hchf@gmail.com

STUDENT ASSISTANCE PROGRAM

All information collected will remain confidential.

Name of Student:_____ School: _____

Gender: ☐ Female ☐ Male **Does Child have Disabilities:** ☐ YES ☐ NO

Race/Ethnicity:

☐ Caucasian ☐ Asian ☐ Hispanic ☐ African ☐American ☐Native American ☐Bi-Racial

Other _____

Primary Language: ☐ English ☐ Spanish Other: _____

Family Dynamics:
(*We ask this information for funding purposes only. All information will remain confidential.)*
Parent/Guardian's Name: _____ Relation to Child: _____

Parent/ Guardian's DOB: _____ Race/Ethnicity: _____

Parent/Guardian's Name: _____ Relation to Child: _____

Parent/ Guardian's DOB: _____ Race/Ethnicity: _____

Household Annual Income: _____ Family Size (# of people living in home): _____

Family Type:
___ Single Female P/G ___ Single Male P/G ___ Two P/G ___ Child living on own

Has or is a Parent/Guardian incarcerated? ☐ N ☐ Y If Yes, relationship to child: _____

Group Type; Please mark all areas/topics in which your child could benefit from:
_____ Self-Confidence _____ Anger Management _____ Divorce/Separation _____ Bullying
_____ Death of a Parent/Guardian _____ Social Interactions = Introvert Extrovert
Other: _____

Comments:

_____

_____

_____

_____

If you have any questions about the program please contact Shyla Perkins 928-453-8190

Lake Havasu Unified School District #1
Special Services Department
2200 Havasupai Blvd.
Lake Havasu City, AZ 86403
928-505-6934 Fax: 928-505-6980

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION AND PROVISION OF SERVICES ON CAMPUS

DATE: _____

Student: _____ Birthdate: _____

School: _____ Grade: _____

As parent/Guardian of the named student, I hereby authorize the mutual exchange of confidential information between the **Lake Havasu Unified School District #1** and:

Agency: Havasu Community Health Foundation, Student Assistance Program

Address: 2126 McCulloch Blvd N, Suite 14
Lake Havasu City, AZ 86403

This information may include but is not limited to: Attendance records, Grades, Progress Reports, Disciplinary Records, and Academic / Behavior Progress.

I give permission for my student to receive on-going case management support and behavioral health services from representatives of agency identified above on school campus.

_____
Parent/Guardian Signature

_____
Date

_____
Address

_____
City, State and Zip Code

In accordance with the requirements of the Family Educational Rights and Privacy Act of 1974, Information sent or received may not be shared with any other party without the written consent of the parent or guardian or the pupil if eighteen years or older. Lake Havasu Unified School District #1 complies with the federal legislation of FERPA and the Health Insurance Portability and Accountability (HIPPA). We are required by law to protect the privacy of the information we have about our students and will only utilize information provided in a student's education and medical record in accordance to procedures and guidelines outlined by FERPA and HIPPA.

Emergency Contacts/Medical Information

Student Name: _____

School:_____ **Grade:**_____

Parent Contact

Name:_____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Parent Contact:

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Primary Contact:

Name: _____

Relation: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Secondary Contact:

Name: _____

Relation: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Any Special/Medical Needs?

_____

_____

_____

Any Known Allergies?

_____

Transportation Information

Student Name: _____

School: _____ **Grade:** _____

How will your child be attending SAP?

Attending Directly After School ☐

Parent Drop Off ☐

Attending from Parks and Recreation ☐

Walking ☐

How will your student be leaving SAP?

Parent Pick Up ☐

Returning to Parks and Recreation ☐

Walking ☐

Other ☐

Who is Authorized to pick up the student other than the parent contact?

Authorized individuals must present ID to pick up students. Only those listed can pick up the student.

Name: _____

Relation: _____

Home Phone: _____ Cell Phone: _____

Address: _____

Name: _____

Relation: _____

Home Phone: _____ Cell Phone: _____

Address:_____

Name: _____

Relation: _____

Home Phone: _____ Cell Phone: _____