

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 at 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 94 Acoma Blvd S. Suite 101, 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



PLEASE KEEP TOP PORTION AS A REFERENCE

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

Telesis Preparatory Academy
2598 Starlite Ln.
Lake Havasu City, AZ 86403
928-855-8661 Fax: 928-855-9302

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 Telesis Preparatory Academy and:

Agency: Havasu Community Health Foundation, Student Assistance Program

Address: 2126 McCulloch Blvd N

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.