



SAP PARENT/GUARDIAN CONSENT

Your child, _____; has been referred to the CLASS Academy Student Assistance Program (SAP). This voluntary program is available to offer supportive services to students experiencing academic, behavioral, and/or emotional difficulties that may pose barriers to school success.

Students can be referred to the SAP by parents/guardians, school personnel, peers or self-referrals. The SAP team is comprised of specially trained teachers, administrators, school counselors and a mental health and/or drug & alcohol consultant(s). Our goal is to work with you and to offer support and recommendations for your son/daughter. Where barriers are beyond the scope of the school, the team can provide information so families may access community resources.

You are a vital part of the team and the SAP team values the importance of parent/guardian involvement in this process. A team member is ready to talk with you about the referral and obtain information about your child. With your permission, our Student Assistance Team will initiate the SAP process which includes meeting with your son/daughter.

Please complete the bottom portion of this letter and return it to:

CLASS Academy
270 Ohio River Blvd, Baden PA 15005. Attn: Carley Tonks, *Prevention Specialist & SAP Coordinator*

If you have any questions about the Student Assistance Program, please contact CLASS Academy at 724-869-2222.

PLEASE SIGN BELOW:

_____ I give permission to proceed with the student assistance process and for a member of the SAP team to interview my child,
_____.

_____ I do not give permission to proceed with the Student Assistance Program.

PARENT SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____



SAP PRESCREEN CONSENT

STUDENT NAME: _____ **D.O.B.** _____ **GRADE:** _____

_____ I give for permission for my son/daughter to participate in a confidential pre-screening conducted by the SAP Liaison during school hours at my child's school building. I understand that his 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 connections 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 tool that will be used with my child.

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

Please complete the bottom portion of this letter and return it to:

CLASS Academy
270 Ohio River Blvd, Baden PA 15005. Attn: Carley Tonks

If you have any questions about the Student Assistance Program, please contact CLASS Academy at 724-869-2222.

PLEASE SIGN BELOW:

PARENT SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

STUDENT NAME: _____ **GRADE:** _____

Your son or daughter has been referred to the Student Assistance Team. The Student Assistance Program (SAP) is designed to assist parents in helping their child affectively deal with issues that may be barriers to their success and learning. The information gained through this process will be used to help determine the best way we can help your child. This form is a questionnaire used to identify your child's strengths and challenges. Please complete the following information as soon as possible and return to school.

Student Name: _____ Date: _____ D.O.B. _____ Parent / Guardian Name: _____

Please check all that you believe best describe your son or daughter:

STRENGTHS:

- | | |
|---|--|
| <input type="checkbox"/> Able to work independently | <input type="checkbox"/> Is a good leader |
| <input type="checkbox"/> Noticeable mood swings | <input type="checkbox"/> Spending a lot more time alone than normal |
| <input type="checkbox"/> Joins in extra curricular activities | <input type="checkbox"/> Can accept criticism |
| <input type="checkbox"/> Frequent, extreme highs and lows | <input type="checkbox"/> Exhibiting general loss of energy, motivation, |
| <input type="checkbox"/> Works well in groups | <input type="checkbox"/> Considerate of others |
| <input type="checkbox"/> Crying seemingly without explanation | <input type="checkbox"/> interest or enthusiasm |
| <input type="checkbox"/> Wants to and likes to learn | <input type="checkbox"/> Good communication skills |
| <input type="checkbox"/> Appearing very irritable or hostile without reason | <input type="checkbox"/> Cooperative |
| <input type="checkbox"/> Displays good logic/reasoning and decision making | <input type="checkbox"/> Possesses good interpersonal skills |
| <input type="checkbox"/> Extremely negative or apathetic attitude | <input type="checkbox"/> Displays positive values(honesty respect, caring) |

FRIENDS & RELATIONSHIPS:

- | | |
|--|---|
| <input type="checkbox"/> Follows Rules | <input type="checkbox"/> Spends less time in family activities |
| <input type="checkbox"/> Uses time wisely | <input type="checkbox"/> Is verbally or physically abusive towards family |
| <input type="checkbox"/> Helps others | <input type="checkbox"/> Does household chores |
| <input type="checkbox"/> Stopped spending time with old friends | <input type="checkbox"/> Generally complies with family rules |
| <input type="checkbox"/> Is connected to and likes school and staff | <input type="checkbox"/> Blaming others / Refusing to take responsibility |
| <input type="checkbox"/> Hanging out with friends you don't know | <input type="checkbox"/> Participates in family activities, meals, etc. |
| <input type="checkbox"/> Strives to Achieve their best | <input type="checkbox"/> Cares about appearance, health, etc. |
| <input type="checkbox"/> Doesn't want you to meet his or her friends | <input type="checkbox"/> Refused to follow family rules. |
| <input type="checkbox"/> Friends immediately go into child's room to | <input type="checkbox"/> Takes appropriate pride in self and property |
| <input type="checkbox"/> Avoid contact with family members | <input type="checkbox"/> Behavior is appropriate with other children |
| <input type="checkbox"/> Not communicating plans or where they are | <input type="checkbox"/> Generally respectful towards adults |

SCHOOL:

- | | |
|--|---|
| <input type="checkbox"/> Experiencing more problems in school than usual | <input type="checkbox"/> Forged your signature |
| <input type="checkbox"/> Recent or rapid drop in academic performance | <input type="checkbox"/> Having problems getting your child to go to school |
| <input type="checkbox"/> Lack of participation in extracurricular activities | |

CRISIS INDICATORS:

- | | |
|--|--|
| <input type="checkbox"/> Has expressed a desire to die | <input type="checkbox"/> Has made suicidal threats / gestures |
| <input type="checkbox"/> Given away personal possessions | <input type="checkbox"/> Has experienced recent death of family member or friend |
| <input type="checkbox"/> Has expressed desire to join someone who has died | |

PHYSICAL INDICATORS:

- | | |
|--|--|
| <input type="checkbox"/> Unsteady on feet | <input type="checkbox"/> Frequent cold-like symptoms |
| <input type="checkbox"/> Noticeable change in height | <input type="checkbox"/> Loss of hair |
| <input type="checkbox"/> Complaining of nausea/stomach aches | <input type="checkbox"/> Self abuse / mutilation |
| <input type="checkbox"/> Glassy / bloodshot eyes | <input type="checkbox"/> Poor hygiene |
| <input type="checkbox"/> Unexplained physical injuries | <input type="checkbox"/> Preoccupied with personal health issues |
| <input type="checkbox"/> Poor motor skills | |

Fatigue / constantly tired
 Disoriented
 Change in sleep habits

Headaches
 Refusal to eat

PHYSICAL TRAITS:

Unsteady on feet
 Noticeable change in height
 Complaining of nausea/stomach aches
 Glassy / bloodshot eyes
 Unexplained physical injuries
 Poor motor skills
 Frequent cold-like symptoms
 Loss of hair

Self abuse / mutilation
 Poor hygiene
 Preoccupied with personal health issues
 Fatigue / constantly tired
 Disoriented
 Change in sleep habits
 Headaches

ADDITIONAL QUESTIONS:

What are your concerns for your child that may be a barrier to his or her learning (if so, please list): _____

What does your child tell you about his/her school experience?: _____

When your child gets angry at home, what usually calms them down?: _____

Other than you, who do you feel your child would define as their main support?: _____

Does your child currently receive outside counseling services? _____ Provider: _____

Has your child been physical to others in school? YES _____ NO _____ To Whom: _____

Child's Favorite Color: _____ Child's Favorite Music Genre: _____ Top Sport: _____

Favorite Subject in School: _____

Favorite Foods: _____

What trigger does your child have: _____

If your child is engaged in community activities, what are they? _____

Does your child have any fears? _____

What is your child's biggest strength? _____
