**Informed Consent for Counseling Group at Oregon Trail Middle School**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of parent/guardian) hereby consent to allowing my child to engage in a counseling group. By signing this document, I recognize the benefits and the risks that come with counseling. Benefits including, but not limited to referral to resources, problem solving, social emotional support, and decision-making. Risks including but not limited to limits to confidentiality and emotional discomfort. Sessions will last 20-30 minutes. The group will meet 1x/week every week for 5 weeks.

I understand that I have the following rights with respect to the counseling group:

(1) I understand that the information disclosed by my child during his/her/their sessions is generally confidential. I understand that confidentiality will be addressed with students in this group.

(2) I understand that I may revoke this authorization at any time by notifying the school counselor or school administration in writing, and I understand that will not have any effect on uses or disclosures prior to receiving the request.

(3) I understand that, on request, I have the right to inspect the content/treatment being provided to my student.

(4) I understand and hereby authorize this consent voluntarily. I do have the option of refusing to sign this authorization.

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

***If you have any further questions/concerns, please contact Chloe Smith,*** [***cnsmith@olatheschools.org***](mailto:cnsmith@olatheschools.org)***, 913-780-7250***