



Family Service Agency of Burbank
Counseling ~ Educating ~ Preventing ~ Advocating
Since 1953

Dear Parent/Guardian,

Thank you for your interest in our school-based counseling program. We are currently able to provide counseling on three middle school, five high school, and eleven elementary school campuses at no charge to the families we serve. If you would like to have your child receive counseling, please complete and sign all forms and return them to us as soon as possible either in person or by mail.

We look forward to working with your child while supporting you and your family. We will contact you before counseling begins to complete a Parent/Child Intake form to gather more information regarding your child's needs. At that time we can let you know who your child will be seeing and on what day.

Our staff is dedicated in providing a positive experience for your child. We would be happy to answer any questions you might have about our program. Please feel free to contact me at the number provided below.

Sincerely,

Ginny Goodwin, LMFT
Director of Operations
School Based Programs



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Dear Parent/s,

We appreciate the opportunity to provide counseling for your child. We look forward to getting to know him/her while providing support for your family.

Please find enclosed a survey we have been asked to conduct by our funders. While it is not required that you participate in the survey, your assistance would be greatly appreciated.

We are grateful to participate with you in supporting your child in counseling. If you have any questions you can contact me at 818 845-7671.

If you decide to participate, please return the completed survey with the parent packet.

Best Regards,

Ginny Goodwin, LMFT
Director of Operations, School Based Counseling Program



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Elementary / Middle / High School Referral Form

School: _____

Referred By: _____

Student: _____ Age: _____ Grade _____

Parents/Guardians: _____

Address: _____

Home/Work/Cell Phone #: _____

1) Why are you recommending this student for this program?

2) Has this student received any disciplinary action in the last 60 days? _____

3) Does this student receive special educational services? _____

If so, what is the service/diagnosis? _____

4) Is the district aware of any information regarding this student receiving previous psychiatric care?

Any hospitalizations? _____ If so, when? _____

List any medications known: _____

5) Has an SST or IEP meeting occurred? Yes _____ No _____ Date _____

Contact Persons: Ginny Goodwin Director of Operations.

The confidential information on this form is legally provided and is intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copy of this form is strictly prohibited. If you have received this form in error, please immediately notify sender by telephone and return the original message to the above at the address via the United States Postal Service.
Thank You.



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All services in our school based counseling programs are confidential. The sharing of any information regarding your student's counseling may be done only after a "release of information" form is signed. _____ (initial)

Your student's privacy will be respected and confidentiality will be maintained with the following exceptions mandated by California law: If the student intends to harm him or herself or another, or if there is reasonable concern or evidence of child abuse, it must be reported to the appropriate authorities and confidentiality would have to be broken. _____ (initial)

PARENT/GUARDIAN AUTHORIZATION FOR MINORS

I, _____, authorize staff at Family Service Agency of Burbank to provide counseling services for my son/daughter _____
Name of Child

I understand that Family Service Agency (FSA) is a teaching clinical facility and that my student may be seen by an intern or pre-licensed clinician. In that case, I understand that my student's counseling will be directly supervised by one of FSA's licensed clinicians certified by the Board of Behavioral Sciences to provide clinical training.

Please note: It is our typical practice to complete a Parent/Child Intake-Assessment form with the referred child's parent/s before services begin. You will be receiving a phone call to complete this form to gather information regarding your child and how we can best serve him/her in counseling. You are welcomed to contact us at 818 845-7671 to expedite the process.

Both parents/guardians must give authorization if there is a joint legal custody agreement.

Parent/Legal Guardian	Date	Phone	email
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Parent/Legal Guardian	Date	Phone	email
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To be filled out by a parent/guardian in a position to observe the student client

Minor Client's Name _____ Date _____

Child's Grade _____ Child's DOB _____ Child's Sex _____

Completed By _____ School Attending _____

<p align="center">To your knowledge Please rate the degree to which your child has experienced the following concerns in the past 30 days.</p>	Not At All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. He/She has not been attending school or has difficulty getting to class/tardies	0	1	2	3	4	5
2. He/She has difficulty at times being truthful	0	1	2	3	4	5
3. He/She displays of high energy physically	0	1	2	3	4	5
4. He/She has physically harmed himself/herself	0	1	2	3	4	5
5. He/She has expressed thoughts of self harm	0	1	2	3	4	5
6. He/She has feelings of loneliness and helplessness	0	1	2	3	4	5
7. He/She is isolating himself/herself	0	1	2	3	4	5
8. He/She has expressed of intense fear or anxiety	0	1	2	3	4	5
9. He/She has expressed worry of negative bad events	0	1	2	3	4	5
10. He/She has seems sad or depressed	0	1	2	3	4	5
11. He/She has difficulty falling asleep, staying asleep, or nightmares	0	1	2	3	4	5
12. He/She has difficulty maintaining healthy eating habits	0	1	2	3	4	5
13. He/She has verbal conflicts with others	0	1	2	3	4	5
14. He/She has physical conflicts with others	0	1	2	3	4	5
15. He/She has difficulty following rules and or directions	0	1	2	3	4	5
16. He/She has negative impulsive behavior	0	1	2	3	4	5
17. He/She has used illicit substances	0	1	2	3	4	5
18. He/She has been involved with law enforcement	0	1	2	3	4	5
19. He/She has difficulty paying attention	0	1	2	3	4	5
20. Other	0	1	2	3	4	5