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 services to students on all Burbank Unified School District 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 FSA at the address listed below.

We look forward to working with your child while supporting you and your family. We will contact you before counseling begins to complete a Patent/Child Intake form to gather more information regarding your child's needs.

Our staff is dedicated in providing a positive experience for your child. Please feel free to contact me at the number provided below.

Best regards,

Ryan Varon, LMFT
Director, School Based Counseling Program

2721 West Burbank Blvd., Burbank, CA 91505
818 845.7671 fax 818 845.2261 ~ www.familyserviceagencyofburbank.org

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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_____

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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School-Based Counseling Program

_____

Students' Name

_____

School

Dear Parents/Guardians:

Our school is very fortunate to have the counseling and educational staff from FAMILY SERVICE AGENCY OF BURBANK available to work with our students. The licensed and pre-licensed clinicians will be meeting with students individually and/or in small groups to help them learn how to better get along with others, and to feel more positive about themselves. All of the pre-licensed clinicians are supervised by a licensed therapist who may occasionally be in the counseling session.

Your child has been selected or has requested to participate in this program. Counseling sessions will be held on campus during the day on a weekly basis. If you would like your child to participate in this excellent program, please sign the consent form below and return it as soon as possible.

Your child's privacy will be respected and confidentiality will be maintained with the following exceptions mandated by California law: if there is reasonable suspicion of child abuse, elder or dependent abuse, threats of violence to a specific victim, or if the student intends to harm him or herself, it must be reported to the appropriate authorities and confidentiality would have to be broken.

I understand that I have read the above and give permission for my child to participate in the counseling program.

Student's Name:_____

Parent's Signature:_____ Parent's Signature:_____

Date: _____ Phone: _____ Email: _____

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Dear Parent/Guardians,

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.

You will also find enclosed a survey we have been asked to conduct by our funders; your participation would be greatly appreciated. If you do choose to participate please return the completed survey with the parent packet.

If you have any questions please feel free to contact me at the number listed below.

We are grateful to join with you in supporting your child.

Best Regards,

Ryan Varon, LMFT
Director, School Based Secondary Counseling Program

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To be filled out by a parent/guardian in a position to observe the student

Minor Client's Name _____ Date_____
Child's Grade _____ Child's DOB _____ Child's Sex _____
Completed By _____
School Attending_____

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

Thank you for your participation.

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Elementary / Middle / High School
Referral Form

School:_____ Date:_____

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: Ryan Varon, LMFT - Director, School Based Secondary Counseling Program

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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