**PARENT / LEGAL GUARDIAN CONSENT FOR VIRTUAL INDIVIDUAL SCHOOL COUNSELING**

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| **STUDENT INFORMATION** | | | |
| **Student Name:** |  | **Grade:** |  |
| **School:** |  | **D.O.B:** |  |
| **Teacher Name:** |  | | |
| Dear Parent/Guardian,  Your child is being offered an opportunity to participate in ongoing individual counseling sessions with his/her school counselor (named below). Please see specific information pertaining to these sessions below. | | | |
| **School Counselor:** |  | **Focus of Sessions:** |  |
| **Skills/Goals for Sessions:** |  | | |
| **Session Duration (Minutes/# of Sessions):** |  | | |
| **Session Dates\*/Times\*/**  **Link(s):** |  | | |
| \*Please note that dates and times may be altered due to unforeseen circumstances.  Parent or guardian permission is required for your child’s participation. If you would like your child to participate, please read and sign the informed consent form below, and return to your child’s school counselor. | | | |
| **ACKNOWLEDGMENT AND STATEMENT OF CONSENT** | | | |

I understand that my child’s school counselor has offered to provide virtual counseling to my child. I hereby authorize and voluntarily consent to the participation of my child in virtual counseling with my child’s school counselor. I understand that the school counselor will have the same licensure/certification and apply the same professional standards as they would during in-person support.

I understand that virtual counseling may include consultation, telephone conversations, and education using interactive audio and video communications. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my child’s virtual counseling sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my child’s virtual counseling session.

I understand that as a parent / legal guardian, I have the right to withhold or withdraw consent at any time without affecting my child’s right to future care.

I understand that the information disclosed by me or my child during the course of virtual counseling is generally confidential. For example, virtual counseling sessions will not be recorded without permission. However, there are legal restrictions to confidentiality which include but are not limited to the following examples: (a) any form of child abuse [neglect, physical, and/or sexual], (b) danger to one’s self [i.e., suicide], and (c) danger to others [e.g., homicide, threat to injure someone, etc.].

I understand that there are potential risks to this technology, including, but not limited to interruptions, unauthorized access, and technical difficulties despite reasonable efforts on the part of my child’s school counselor. To help mitigate security risks, it is recommended I take steps to protect my personal device and data including using a secure Wi-Fi network with a password and using an VBCPS approved video conferencing platform. I hold Henrico County School Board harmless for any failures of third-party technology that result in a loss of data or breach of confidentiality.

I understand that virtual counseling services have a limited scope and care may not be as complete as face-to-face services.

I understand that the use of virtual visits is only allowable at this time due to COVID-19 and are not a permanent service delivery option. This temporary policy will be in effect until Virginia’s public health emergency is lifted.

I understand that virtual counseling does not provide emergency services. If my child is experiencing an emergency situation, I understand that I may access the following resources for immediate support:

1. City of Virginia Beach Crisis Services at (757) 385-0888
2. Kempsville Center for Behavioral Health at (757) 461-4565
3. 911 or nearest hospital Emergency Room
4. 800-273-8255 National Suicide Prevention Lifeline

In addition, I will establish a safety plan with my child’s school counselor that includes coping skills; at least one emergency contact; and the closest emergency room to our location.

By signing this form, I certify:

* That I have read or had this form read and/or had this form explained to me.
* That I am currently located in the Commonwealth of Virginia.
* That I fully understand its contents including the risks and benefits of virtual counseling services.
* That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

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| **SIGNATURE OF PARENT/GUARDIAN/CAREGIVER** | | **DATE** |
| [Signature] | | [Enter Text] |
| **VERBAL CONSENT:** If consent for the use of virtual related services is obtained verbally, documentation of consent must be included. | | |
|  | Consent was received via phone. Documentation of the conversation is attached. | |
|  | Consent was received via phone or text message. A copy of the conversation is attached. | |
|  | Consent was received via email. A copy of the conversation is attached. . | |
| **SIGNATURE OF SCHOOL-BASED MENTAL HEALTH STAFF** | | **DATE** |
| [Signature] | | [Enter Text] |