Weber School District

PARENTAL PERMISSION TO ASSESS RISK

Student:_____ **Date of Birth:**_____

Dear _____, **Parent/Guardian Contact/Email:** _____

(Parent/Guardian)

We are interested in providing an appropriate educational program and supports for each of our students. In order to develop an appropriate program/supports, in some cases, it is necessary to obtain additional information about a student.

We would like to administer the assessment that is marked below. You can contact the Mental Health Specialist for additional information about the assessment(s).

☐ **Previdence Assessment of Risk**

(Possible Areas of Assessment: Self-Harm/Suicide; Bullying; Threat/Aggression; Alcohol & Drugs; Sexual Behavior)

☐ **Other:**_____

Under the Utah Code Sections 53E-9-202 and 53E-9-203 of the Utah Family Education Rights and Privacy Act, school district personnel are required to have your consent as parent or legal guardian, except in an emergency situation requiring immediate aid or action, if personal information is sought from your child. Copies of the assessment(s) are available from Student Services. Under the codes cited above, parents/guardians are given two weeks to review the documents unless the parent waives that right.

During the assessment personal issues may need to be addressed. Your signature is evidence of approval for _____, Mental Health Specialist, to discuss the issues with your child. The Mental Health Specialist is also the person you should contact if you have any questions about the meaning of a particular question when you are completing your portion of the assessment.

When the evaluation is completed, a meeting will be arranged with you to review and discuss the results. The information gained by this evaluation should be helpful as we work together to develop an educational plan and/or behavioral interventions for your child.

_____ _____

Date of Contact **Mental Health Specialist**

.....

SELECT & SIGN JUST ONE

I hereby authorize the evaluation requested for my child and I waive the two-week notification requirement so testing may begin immediately.

_____ _____

Parent/Guardian Signature **Date**

I authorize the evaluation requested for my child, but do not waive the two-week waiting period. I will contact the Mental Health Specialist to review the assessment(s) within the two-week period.

_____ _____

Parent/Guardian Signature **Date**

I do not authorize the evaluation requested for my child.

_____ _____

Parent/Guardian Signature **Date**