



CHAMINADE HIGH SCHOOL

340 JACKSON AVENUE • MINEOLA, NEW YORK 11501-2441
TEL: (516) 742-5555 • FAX: (516) 742-1989 • WWW.CHAMINADE-HS.ORG

Authorization for Counseling

Dear Parent/ Guardian

Your child has been referred to our school psychologist, Mrs. Maureen Shannon, through our guidance department.

Your consent is needed for your child to be seen. If you provide consent, counseling services will be provided at no cost to you. The provider will be in contact with you periodically and you may contact her at any time. You may also withdraw consent at any time via written request.

If you have any questions or wish to discuss this referral further, please contact Mr. Daniel Petruccio by calling 516-742-5555 ext. 431.

Student's Name _____ Date of Birth _____

Student's Address _____

I give consent for my child to receive counseling from Mrs. Maureen Shannon, School Psychologist.
516-742-5555 ext. 437.

Printed Name of Parent/Guardian _____ Relationship _____

Parent/Guardian
Signature _____ Date _____

Parent/Guardian Contact Info _____

- This consent is valid for one (1) year.