

**CARON TREATMENT CENTERS  
STUDENT ASSISTANCE PROGRAM (SAP)**

**CONSENT TO BEHAVIORAL HEALTH ASSESSMENT**

I acknowledge that \_\_\_\_\_ (student's name) has been referred to the school district's Student Assistance Program (SAP) and that a behavioral health assessment to be conducted by a SAP Specialist from Caron Treatment Centers has been recommended by the SAP core team.

I understand that a credentialed SAP Specialist from Caron Treatment Centers will perform the behavioral health assessment at no cost to me.

I hereby authorize the assigned SAP Specialist to conduct the behavioral health assessment either in-person or remotely via video or audio-conferencing technology. I understand that the results and recommendations of the behavioral health assessment are confidential and will be shared with me and the school district's SAP team, with the appropriate releases signed by the student.

I understand that if the behavioral health assessment is completed remotely, I am agreeing to have my student participate using video and audio-conferencing technology.

I further understand that all related follow-up support may be conducted either in-person or remotely via video or audio-conferencing or electronically through email by the Caron SAP Specialist.

By signing this form, I certify:

- That I permit my student to participate in a behavioral health assessment and related follow-up support, in person or remotely through Caron's Student Assistance Program.
- That I fully understand its contents and have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

\_\_\_\_\_  
Student Printed Name

\_\_\_\_\_  
Student Email Address

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Parent/Guardian Physical Address

\_\_\_\_\_  
Parent/Guardian Email Address

\_\_\_\_\_  
Parent/Guardian Phone Number

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date