

Parent Consent to Refer to a Tomball ISD Wraparound Partner

Student Name:	Student ID.
Student Grade:	_ School Name:
Your signature below as the parent/guardian of the Tomball ISD staff to make a referral for counseling wraparound partners. This consent to refer your streatment. You are granting the designated provide more information about their services and the option Please check the wraparound partner below:	or mentoring services to one of our tudent is not a commitment to or a consent for er permission to contact you directly to provide
Clearhope Counseling & Wellness - CounselingTexas Child Access Through Telemedicine (TCHATT) - CounselingFriends of the Children Houston - Mentoring. I consent to a one-time student observation by Friends of the Children staff prior to enrollment.	
Note: There is a 10 session limit for Clearhope du	e to its grant funding.
I certify that this form has been fully explained to recommunity counseling resources available. I have understand its contents. I understand that I can remy student's school counselor.	read it or have had it read to me, and I
Signature of Patient/Parent/Guardian:	Date:
Printed Name of Parent/Guardian:	
Relationship to Patient:	