In the 2026-27 school year the _____is partnering with the Mental Health, Addiction and Recovery Services (MHARS) Board of Lorain County to provide mental health wellness checks for students who demonstrate behaviors that may signal the need for mental healthcare. It has become increasingly clear that social and emotional variables play a large role in the academic success of students. As such, this year we are planning to screen for mental health concerns, just as we would screen for vision or hearing if there were a reason to suspect that intervention may be helpful.

The MHARS Board of Lorain County has agreed to fund a mental health consultant from one of the community mental health agencies to screen students for mental health symptoms that are common for youth (e.g., anxiety, depression,). With your permission, the mental health consultant will speak to your child, his/her school staff and to you in order to better understand if mental health services may be needed. The consultant may also utilize a behavioral health screening such as the one attached.

This screening service is provided at no cost to the student and family. The service is not a mental health assessment, nor is it a therapy service. Rather, it is a screening that is for the purposes of (1) identifying if mental health services are needed and (2) if so, assisting you in connecting your child to the needed service. Personal information or records obtained by the clinician will be kept secure and private. **Your signature will authorize your child to participate in a mental health wellness check if he or she is identified as having a possible need.**

Name of Parent/Legal Guardian _____

Signature of Parent/Legal Guardian_____ **Date** _____

Phone Number: _____ **Best Time to Call:**_____

Because the mental health consultant providing the screening is not an employee of our school, the student's parent or guardian must sign a release of information which allows for the consultant to gather information and share recommendations with school staff. **By signing below or giving verbal consent , you are providing permission for the mental health consultant to gather information and share recommendations with school staff.**

Re (Student Name): _____Date of Birth: _____

I, (*name of parent/guardian*)_____,(*choose one): mother, father, guardian* of the above named student, hereby authorize the mental health consultant working with my school to share information & maintain records about the above named student with my child's _____staff for the purpose of coordinating services. I understand that the Consent for the Release of Information expires at the end of the current school year. I also understand that I may revoke this Consent for Release of Information at any time by signing and dating a written statement indicating that I would like the release revoked and delivering it to my school principal, who will share it with the mental health consultant. I recognize that if I revoke my consent, this does not include any information which has already been shared between the time that I gave permission to share information and the time it was cancelled. I understand that my signing or refusing to sign this consent will not affect services that I am eligible for within the school. *The information disclosed is in accordance with federal and state confidentiality rules; Federal regulation (42 CFR part 2) and prohibits re-release of drug and alcohol information without specific written consent.*

_____ _____

Signature of Parent/Legal Guardian DATE

_____ _____

Signature of Student DATE