



Youth Screen Consent Form

Please return this form to the school prior to the screening date if you would like to participate.

By signing below, I agree I have read and understand the description of the Youth Screen program.

___ **(16 or older only)** Yes, I do want to participate in the Youth Screen program

___ Yes, I do want my child to participate in the Youth Screen program.

___ No, I do not want my child to participate in the Youth Screen program.

Student's Name (Print): _____ Age: _____

Student's Signature **(16 or older only)**: _____

Parent/Legal Guardian's Signature (ages 15 and under): _____

Parent/Legal Guardian's Name (Print): _____

Date of Signature: _____

If you are participating, please provide the following information so we can contact you if necessary:

Parent/Legal Guardian Phone # **(required for all participants)**: _____

Youth Phone # **(if 16 or older)**: _____

Email Address: _____

Home Address: _____

The best times to reach you:

1) _____ 2) _____

PLEASE NOTE: IF IN THE JUDGMENT OF THE CLINICIAN YOUR CHILD IS IN IMMEDIATE RISK OF INJURING THEMSELVES OR OTHERS, WE WILL INFORM YOU IMMEDIATELY. IF YOU ARE NOT AVAILABLE, WE WILL TAKE THE APPROPRIATE MEASURES TO PROTECT YOUR CHILD AND INFORM YOU AS SOON AS POSSIBLE.