

MENTAL HEALTH INFORMATION
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Student Name: _____

This section to be completed by Parent/Guardian:

1. Is your child currently seeing a therapist (counselor/psychologist)? _____ No _____ Yes

If Yes . . .

Therapist's Name: _____

Telephone: _____ Office Address: _____

How long has your child seen this therapist? _____

How often do they currently see this therapist? _____

Will they continue to see this therapist while attending SMA? _____

Diagnosis or diagnoses:

2. Is your child currently seeing a psychiatrist? _____ No _____ Yes

If Yes . . .

Psychiatrist's Name: _____

Telephone: _____ Office Address: _____

How long has your child seen this psychiatrist? _____

How often do they currently see this psychiatrist? _____

Will they continue to see this psychiatrist while attending SMA? _____

Diagnosis or diagnoses:

3. Will you need a referral for your child to start meeting with a new therapist or psychiatrist while attending SMA?
_____ No _____ Yes

4. In order to ensure continuity of care, I hereby grant permission for the above referenced therapist/psychiatrist to release information to the Mental Health Counselor at San Marcos Academy, and for the San Marcos Academy Mental Health Counselor to share information with the above referenced therapist/psychiatrist.

Printed Name of Parent/ Guardian Signature Relationship to Student Date