

**MENTAL HEALTH CONSULTATION FORM**

I, \_\_\_\_\_, give my permission to the Sequatchie Valley  
(Parent/Guardian)

Head Start Program Mental Health Provider \_\_\_\_\_ to:  
(Provider's Name)

(check all that apply)

\_\_\_\_\_ observe my child, \_\_\_\_\_ in the classroom.  
(Child's Name)

\_\_\_\_\_ discuss with me (parent) about my current concerns.

\_\_\_\_\_ to provide classroom consultation regarding my child.

A report will be written by the Mental Health Provider and filed under lock and key with the Mental Health Coordinator. The report will be confidential and only the parent(s), the Provider, and the Coordinator will have access to said report.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date