Please check one of the following and return to school:

\_\_\_\_\_ Yes, I give permission for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to participate in individual counseling sessions with Mrs. Earle, School Counselor.

\_\_\_\_\_No, I do not give permission for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to participate in individual counseling sessions with Mrs. Earle, School Counselor.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**