PARSONS COUNSELING & PLAY THERAPY CENTER

Authorization of Release for School Check-Out for Counseling Services

Date: _____

Student Name: _____

Date of Birth: _____ Grade: _____

School: _____

Has permission been signed in school office for check-out? ☐ Yes ☐ No

Parent / Legal Guardian(s) Name: _____

Home Phone: _____ Cell Phone: _____

Address: _____

I hereby grant permission for my child to be counseled by Parsons Counseling, LLC. This counseling may occur either at the student's school or at Parsons Counseling & Play Therapy Center, for which I give Parsons Counseling permission to check my child out of school and return them to school immediately following counseling session for the duration of said counseling period. I do not hold Madison County Schools responsible for my child during the period after check-out and prior to check-in when returning to school. Further, I do not hold Parsons Counseling liable for any accidents as a result of walking to and from said counseling sessions.

_____ _____
Signature of Parent / Legal Guardian Date

_____ _____
Witness Date

P.O. Box 802, Berea KY 40403 859.428.7862 www.parsonscounseling.com