

# **TAMAQUA AREA HIGH SCHOOL**

500 PENN STREET

TAMAQUA, PA 18252

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## **STUDENT ASSISTANCE PROGRAM (SAP) PARENTAL CONSENT FOR SAP PARTICIPATION**

Dear Parent/Guardian:

Your child, \_\_\_\_\_, has been referred to participate in the Student Assistance Program of the Tamaqua Area School District. Your child will meet with a professional person involved with the SAP program. This process may include assessment and possible ongoing services. Please fill in the information below and sign and date where indicated.

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**STUDENT NAME:** \_\_\_\_\_ **GRADE:** \_\_\_\_\_

**STUDENT ADDRESS:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**SOCIAL SECURITY NUMBER:** \_\_\_\_\_

**FATHER'S NAME:** \_\_\_\_\_

**MOTHER'S NAME:** \_\_\_\_\_

**GUARDIAN'S NAME** (If applicable): \_\_\_\_\_

**Does Parent/Guardian have any form of medical insurance?**    YES    NO

**NAME OF INSURANCE:** \_\_\_\_\_

**INSURANCE IDENTIFICATION NUMBER:** \_\_\_\_\_

**INSURANCE PHONE NUMBER:** \_\_\_\_\_

**ACCESS NUMBER:** \_\_\_\_\_

I understand that the Student Assistance Team may need to release any pertinent and relevant information from my child's school records to appropriate person/agencies for the purpose of the assessment/referral. I give permission for my child to participate in the Student Assistance Program.

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

\_\_\_\_\_  
Date

\*\*\*\*\*SAP PARTICIPATION AND INFORMATION RECEIVED WILL REMAIN CONFIDENTIAL AND NOT A PART OF STUDENT'S PERMANENT RECORD\*\*\*\*\*