Regulation 270 FormB

CARSON CITY SCHOOL DISTRICT
PARENTAL/GUARDIAN CONSENT FOR CLINICAL SUICIDE RISK ASSESSMENT

As a result of an initial safety screening, the Carson City School District is concerned that your child _____, a student within the Carson City School District ("CCSD"), may be at risk for suicide or self-injury. CCSD takes student safety seriously, and although you have ultimate responsibility for decisions regarding your child's mental health care needs, CCSD desires to take action to help assure your child is safe.

Your child's school, _____, within the CCSD, wishes to refer your child for a clinical Suicide Risk Assessment, which will be conducted by a duly licensed behavioral health community provider. This is a free and confidential service. The Suicide Risk Assessment will help determine if your child/student is at risk for suicide or self-injury. It may also recommend a course of treatment for your child.

By initialing on the first line below, signing below, you:

- Authorize your child's school within the Carson City School District to contact the behavioral health community provider identified below for a free, confidential, clinical Suicide Risk Assessment, and
- Authorize your school within the Carson City School District to release confidential information obtained by the school's first responder who conducted the initial safety screening, to the behavioral health provider who will be completing the clinical Suicide Risk Assessment.

_____ The undersigned parent/guardian hereby acknowledges receipt of the request for a Clinical Suicide Risk Assessment, and I hereby consent to the same by _____, a duly licensed behavioral health provider. I understand that the results of the assessment, and any recommendations resulting from the assessment, will be discussed with and explained to me.

_____ The undersigned parent/guardian hereby refuses a Clinical Suicide Risk Assessment. I assume responsibility for my child's mental health treatment and follow-up, including having a clinical suicide risk assessment completed outside of school, seeking mental health treatment on my own, or, to otherwise decline treatment.

As the parent/guardian of the child, I understand that I have ultimate responsibility for decisions regarding the health and well-being of my child, including his or her mental health.

_____

Print Student Name

_____ _____

Signature of Consenting Parent or Guardian Date

_____ _____

Print Name of Consenting Parent or Guardian Date

_____ _____

Signature of School First Responder Name Date

_____ _____

Print Name of School First Responder Date

January 29, 2019