I hereby give consent for my child, _________________________________, to participate in counseling services at the Winston School. The type (individual and/or group counseling) and frequency/duration (i.e., 30, 45, or 60 minutes/week) of counseling sessions is indicated below. Commonly, individual sessions occur once per week, lasting 30 or 60 minutes, and group sessions occur once a week for 45 minutes. I understand that the counseling sessions will be provided by professionally trained counselors, who work at the Winston School. The counselor(s) that will be assigned to work with my child has/have received advanced training in the fields of counseling and psychology. Below are the names, degrees/credentials, and contact information for all of the counselors at the Winston School. All counselors at the Winston School receive supervision by a licensed clinical psychologist, Dr. Ian Schere, Ph.D., PSY19284.

Jacob Garrett, MA  
Counselor  
Associate Professional Clinical Counselor, 5270  
Jacob.Garrett@thewinstonschool.org

Manny Ocana, MA  
Practicum Student  
Manny.Ocana@thewinstonschool.org

Jacob Ambrose, MA  
Practicum Student  
Jacob.Ambrose@thewinstonschool.org

Erika Kyte, MSW  
Counselor  
Associate Clinical Social Worker, 86058  
Erika.Kyte@thewinstonschool.org

Eric Foster, MA  
Practicum Student  
Eric.Foster@thewinstonschool.org

Carlie Lakin, MA  
Practicum Student  
Carlie.Lakin@thewinstonschool.org

I also recognize that as with any type of counseling and/or psychotherapeutic treatment, certain risks may be involved as well as potential benefits of my child’s participation in the Winston School Counseling Program. I acknowledge and accept that the Winston School and the counselor(s) assigned to work with my child are aware of these risks and benefits and that every effort will be made on their part to minimize risks and any potential harm and to maximize benefits and safety in providing counseling services to my child. When appropriate, students will also be administered brief assessment measures to support treatment goals and interventions.

Finally, I understand that all of the information that my child discusses with his/her counselor, in session, will be kept strictly confidential by the clinician except where limitations and/or exceptions apply according to state law and/or ethical guidelines, [i.e., reported child abuse, elder abuse, suicidal intentions/gestures and/or harm-to-others (Tarasoff) circumstances, court order, possession of age-restricted/illegal substances on school property]. As needed, the following Winston School staff will have access to my student’s counseling files: Head of School, Assistant Head of School, Director of Special Education, Clinical Supervisor, Clinical Coordinator, Assistant Dean of School, Dean of Students, Case Manager and counselors. Further, I have been advised that any release of confidential information made to third-party sources regarding my child’s counseling will only be done after a written Releases of Information has been authorized by myself and assent by my child has been given.
I understand that my child’s participation in counseling is voluntary and he/she or I can decide to withdraw consent and stop counseling services at any time without penalty. This consent form expires at the end of the 2019-2020 school year (August 7, 2020).

Please initial, indicating your agreement, next to the appropriate counseling service you would like your child to receive.

☐ Individual Counseling: 30 or 60 minutes/week  Initials ____________
☐ Group Counseling: 45 minutes/week  Initials ____________

My signature indicates that I have read and agreed to the above:

Student / Child’s Name: ________________________________ Date: ____________

Student’s Signature: ________________________________ Date: ____________
(Only required if student is over the age of 18)

Signature of Parent / Guardian: ________________________________ Date: ____________