South Central Community School Corporation
9808 South 600 West | Union Mills, IN 46382
Phone: 219-767-2263 | Fax: 219-767-2260 | www.scentral.k12.in.us
Home of the Satellites!

Risk Assessment Agreement Form

The student must be seen by a mental health professional or doctor and released to come back to school. We need to have a written statement stating that the student is not a danger to themselves or others. We must have this clearance before the student can return to school.

I, _____ , the parent/guardian of _____ (student) (DOB: _____), who is enrolled in South Central Community School Ciorporation have been informed by _____, Counselor/Social Worker/Administrator, at _____(school) that the above-listed student, has made statements or displayed actions that warrant a concern for the safety of the above listed student, a fellow student(s), and/or school personnel.

South Central Community School Corporation is requesting that the parent/guardian have a risk assessment completed by a licensed mental health professional. If the parent/guardian refuses to take this action, it may result in a report of emotional neglect to the Department of Child Services.

The parent/guardian understands and agrees that all costs related to this evaluation will be their financial responsibility, and that the South Central Community School Corporation will not be financially responsible for any costs related to testing and/or treatment.

The above-listed student will be placed on a leave of absence from South Central Community School Corporation until a full risk assessment is completed and the student is released by a Mental Health Professional or doctor to return to school.

The above-listed parent/guardian further permits the referring counselor/social worker/administrator of the South Central Community School Corporation and the mental health provider chosen by the parent/guardian to exchange information concerning the student listed above. This release will be in effect for one school year or until the parent/guardian revokes this agreement in writing to South Central Community School Corporation.

Parent/Guardian Name: _____ **Date:** _____

Patient/Student Name: _____ **Date:** _____

Couselor/Administrator Name: _____ **Date:** _____

School to keep one copy, one copy given to Parent/Guardian for the Mental Health Professional, and one copy for their records. Parent/Guardian is to provide the name and phone number of the Mental Health Professional to the counselor/Social Worker/Administrator within 48 hours.

For counselor/administrator use only:

Mental Health Professional/Physican Name: _____

Phone Number: _____