## Downstate School Counseling Program Division of School Psychology Alfred University Alfred, New York 14802

## **Counseling Consent Form**

I give permission for my child,		
to receive counseling from,	, Alfred University counseling graduate student, as	s part of the
	graduate student will be supervised by faculty from the	
University Counseling Program. I also un	nderstand that counseling is being offered to my child on	ı a voluntary
basis and I may withdraw my child from c	counseling at any time.	
Date	Parent Signature	
	Parent Name (Please print.)	
0	 Optional Consent to Audiotape	-
sessions is not required, it does allow the gas a counselor. If you would be in favor or read and sign the additional consent form	ou want your child to receive counseling. While audio/vigraduate student to receive feedback regarding his or her of allowing your child's counseling sessions to be audiotabelow. If you consented to counseling but do not conse	r performance aped, please
audiotaping, your child will still receive co	ounseling and will not be audiotaped.	
information recorded on the audiotapes is	my child, I understant confidential and that the taped sessions will be reviewed	nd that d only by the
	Alfred University Counseling Program, for the purpose deeing my child. I also understand that the tapes will be exed.	
Date	Parent Signature	

If you have questions or would like further information about this activity please contact: Dr. Robert Bitting, Practicum Coordinator, Alfred University School Counseling Program - Downstate, 1 Saxon Drive, Alfred, NY 14802, 607-871-2212, <a href="mailto:bitting@alfred.edu">bitting@alfred.edu</a>