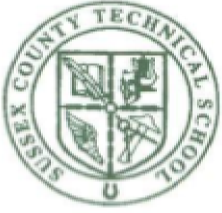

SUSSEX COUNTY TECHNICAL SCHOOL

School Based Youth Services Program - The Student Center

DOES MY STUDENT NEED COUNSELING?

Please indicate below the areas for which your student may require support. All information is strictly confidential and will only be shared with the clinician the student is assigned and the clinician's supervisor.

*If you are receiving this form in a summer mailing, please note it is an *optional* form.

ACADEMIC

	Poor/failing grades		Poor attendance
	Disciplinary in class		Homework refusal
	Appears to seek negative attention		Resists authority
	Appears to "zone out" in class		

PERSONAL

	Trouble falling asleep		Gender Issues
	Trouble staying asleep		Self-injury
	Trouble getting up		Suspect someone has abused them
	Change in appetite		Can't keep friends
	Eating more		Poor social skills
	Eating less		Shy
	Restricting food		Neglects proper hygiene
	Speaks of suicide		Poor peer relations
	Change in appearance		Hangs out with the "wrong crowd"
	Perfectionist		Poor sibling relationship(s)
	Suspect drug or alcohol use		Has possessive boyfriend/girlfriend
	Appears promiscuous		Sexual identity issues
	Defiant/rebellious		"Needy" – lack of independence
	Is abusive to others/animals		Steals

FAMILY

	Alcohol/drug user in family		Family member with psychiatric issues
	Family life in disruptive state		Recently moved from out of town
	Death in family or circle of friends		Family stressors: financial, marital, other

Student Name (please print):____Grade: ____________

Parent/Guardian name (please print) and preferred contact information:

____

Please schedule my child with a professional counselor. I have signed the necessary consent forms in this packet marked "Parental Consent for Professional Counseling Form". (Initial)______________

Please contact me prior to scheduling my child. (Initial)______________

Please Check here if your student is 16 years old ______ Student's Date of Birth _____/_____/______

tm/2021