

## PARENT / LEGAL GUARDIAN CONSENT FOR VIRTUAL COUNSELING

### STUDENT INFORMATION

**Student Name:** [Enter Text]

**Grade:** [Enter Text]

**Date of Birth:** [Enter Text]

**School Name:** [Enter Text]

### ACKNOWLEDGMENT AND STATEMENT OF CONSENT

I understand that my child's school counselor/psychologist/social worker has offered to provide virtual counseling to my child during school closure due to the COVID-19 nationwide public health emergency. I hereby authorize and voluntarily consent to the participation of my child in virtual counseling with my child's school counselor /psychologist/social worker. I understand that the school-based mental health provider will have the same licensure/certification and apply the same professional standards as they would during in-person support.

I understand that virtual counseling may include consultation, telephone conversations, and education using interactive audio and video communications. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my child's virtual counseling sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my child's virtual counseling session.

I understand that as a parent / legal guardian, I have the right to withhold or withdraw consent at any time without affecting my child's right to future care.

I understand that the information disclosed by me or my child during the course of virtual counseling is generally confidential. For example, virtual counseling sessions will not be recorded without permission. However, there are legal restrictions to confidentiality which include but are not limited to the following examples: (a) any form of child abuse [neglect, physical, and/or sexual], (b) danger to one's self [i.e., suicide], and (c) danger to others [e.g., homicide, threat to injure someone, etc.].

I understand that there are potential risks to this technology, including, but not limited to interruptions, unauthorized access, and technical difficulties despite reasonable efforts on the part of my child's school counselor /psychologist/social worker. To help mitigate security risks, it is recommended I take steps to protect my personal device and data including using a secure Wi-Fi network with a password and using an HCPS approved video conferencing platform. I hold Henrico County School Board harmless for any failures of third-party technology that result in a loss of data or breach of confidentiality.

I understand that virtual counseling services have a limited scope and care may not be as complete as face-to-face services.

I understand that the use of virtual visits is only allowable at this time due to COVID-19 and are not a permanent service delivery option. This temporary policy will be in effect until June 12, 2020, or when Virginia's public health emergency is lifted, whichever date is soonest.

I understand that virtual counseling does not provide emergency services. If my child is experiencing an emergency situation, I understand that I may access the following resources as a part of the safety plan:

1. Henrico Area Mental Health
  - a. 804-727-8515 (Same Day Access) or
  - b. 804-727-8484 (Emergency).
2. 911 or nearest hospital Emergency Room
3. 800-273-8255 National Suicide Prevention Lifeline

In addition, I will establish a safety plan with my child's school counselor /psychologist/social worker that includes coping skills; at least one emergency contact; and the closest emergency room to our location.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I am currently located in the Commonwealth of Virginia.
- That I fully understand its contents including the risks and benefits of virtual counseling services.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

**SIGNATURE OF PARENT/GUARDIAN/CAREGIVER**

**DATE**

[Signature]

[Enter Text]

**VERBAL CONSENT:** If consent for the use of virtual related services is obtained verbally, documentation of consent must be included in the student's cumulative file.

Consent was received via phone. Documentation of the conversation is included in the student's cumulative file.

Consent was received via phone or text message. A copy of the conversation is included in the student's cumulative file.

Consent was received via email. A copy of the conversation is included in the student's cumulative file.

**SIGNATURE OF SCHOOL-BASED MENTAL HEALTH STAFF**

**DATE**

[Signature]

[Enter Text]