CROW CREEK TRIBAL SCHOOL
Counseling Packet

Your privacy is important to us, and we believe that counseling is most effective when students feel comfortable speaking openly with their counselor. We hope this information will clarify our privacy policies. In the usual course of events, you have the right to keep your child's counseling here completely private. This means that, without your written permission, no information about your contact with CCTS Mental Health Counselor is available to anyone outside of CCTS, including other faculty & staff, family members, friends, or outside agencies. There are certain exception to confidentiality, noted below, with which you should be aware before you enter into a counseling relationship. Please read carefully through these exceptions, and be sure to ask your counselor if you have any questions.

Exceptions to Confidentiality

- If appropriate, your counselor may consult with your treating physician or other healthcare provider at IHS to coordinate your care;
- If your child pose a threat of harm to yourself, to another person, we will take whatever steps are required by law, or permitted by law, to help prevent the potential harm from happening. This may include contacting your family health officials
- In the event of a psychiatric hospitalization
- If you report information indicating that a child, disabled, or elderly person is suffering abuse or neglect;
- A court order, issued by a judge, could require us to release information contained in your records, or could require a therapist to testify;

I have read and discussed the above information with my counselor. I have been given the opportunity to ask questions and discuss any concerns about these matters. I understand the risks and benefits of counseling, the nature and limits of confidentiality and expectations.

Please sign and date below

Parent/Guardian Signature: _____ Date: _____
Student's Signature: _____
Counselor's Signature: _____ Date: _____

•••••• Please Complete Referral Form••••••

CROW CREEK TRIBAL SCHOOL

CONSENT FOR COUNSELING

Student: _____
Parent/Guardian: _____
Phone Number: _____
Email: _____

I give permission for my child _____ to receive counseling services through CROW CREEK TRIBAL SCHOOL. My signature below indicates that I understand that the counseling service is designed to help my child as he or she attends individual and/or group counseling sessions with the school mental health counselor, Brittany Pieke NCC M.Ed. This form is valid for one calendar year following the signed date.

I understand that, as the parent/guardian of a minor, I legally have access to all information regarding my child's treatment at Crow Creek Tribal School. However, I also understand that some measure of trust and confidentiality is necessary in order for my child's treatment to be as effective as possible. Crow Creek Tribal School has my full consent to treat my child/adolescent, and I understand that the counselor will notify me of any significant information and will update me regularly regarding my child's treatment.

Please sign and date below

Parent/Guardian Signature: _____ Date: _____
Student's Signature: _____
Counselor's Signature: _____ Date: _____

School Counseling Referral Form

Student: _____ Date_____

Grade_____ Teacher_____

••••••Reason for referral (check all that apply)••••••

Academic:

- ☐ Attendance
- ☐ Underachievement
- ☐ Homework
- ☐ Other_____
- ☐ Study Skills
- ☐ Organization
- ☐ Goal Setting

Personal/Social:

- ☐ Anger Management
- ☐ Bullying
- ☐ Social Skills/Friends
- ☐ Negative Attitude
- ☐ Withdrawn/Shy
- ☐ Honesty
- ☐ Self-Esteem
- ☐ Personal Hygiene
- ☐ Trauma
- ☐ Adjustment
- ☐ Family Conflict
- ☐ Health (family or self)
- ☐ Grief (Loss/Death)
- ☐ Uncooperative/ Defiant
- ☐ Anxiety
- ☐ Theft/ Vandalism

Other _____

Comments:_____

_____

_____

Please sign and date below

••••••

Parent/Guardian Signature: _____ Date: _____

Student's Signature: _____

Counselor's Signature: _____ Date: _____