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 part of the student's practicum. I understand that the graduate student will be supervised by faculty from the Alfred University Counseling Program. I also understand that counseling is being offered to my child on a voluntary basis and I may withdraw my child from counseling at any time.

_____ _____
Date Parent Signature

_____
Parent Name (Please print.)

Optional Consent to Audiotape

Parental consent is necessary if you want your child to receive counseling. While audio/videotaping of sessions is not required, it does allow the graduate student to receive feedback regarding his or her performance as a counselor. If you would be in favor of allowing your child's counseling sessions to be audiotaped, please read and sign the additional consent form below. If you consented to counseling but do not consent to audiotaping, your child will still receive counseling and will not be audiotaped.

I give permission to _____, Alfred University Counseling graduate student, to audio/videotape counseling sessions with my child, _____. I understand that information recorded on the audiotapes is confidential and that the taped sessions will be reviewed only by the counselor-supervisor an faculty from the Alfred University Counseling Program, for the purpose of providing feedback to the graduate student who is seeing my child. I also understand that the tapes will be erased or recorded over after they have been reviewed.

_____ _____
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, bitting@alfred.edu