Student Counseling Intake Form

**Please Return Forms to Resa Jimenez MA, at Akin Elementary.  
Phone**: 806-839-2121 extension 402  
**Email**: rjimenez@hcisdowls.net

**Demographic & Contact Information**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Homeroom Teacher \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room # \_\_\_\_\_

School (please circle) Akin - Carr Counselor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/ Guardian Names** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phones** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work Phone** (only for emergencies) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email** (if you check it regularly) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ok to leave messages?** (check all that apply) Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_ Email \_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State** \_\_\_\_ **Zip** \_\_\_\_\_\_\_\_

**Referred by:** \_\_\_\_\_Teacher \_\_\_\_\_Alternate Counselor \_\_\_\_\_Principal \_\_\_\_\_Parent

**Demographic & Contact Information**

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist (if you have seen before) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of any Medical Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications/ dosage Reason it was Prescribed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA Notice of Privacy Practices**

I have received or been provided the opportunity to review a copy of HIPAA Notice of Privacy Practices. I understand that Akin Elementary Services may use and disclose my protected health information (PHI) to carry out counseling services.

This authorization permits HCISD Counseling Staff to discuss information about the student in counseling with the appropriate guardian.

1. I understand that if a conflict arises, the adult that will be consulted will include the legal guardian as well as the adult that is providing consistent care for the child.
2. I understand that if my child transfers to another school district, HCISD staff will inform the counselor at that location that counseling services were being received. No other information will be given unless written permission is sent to Resa Kay Jimenez MA at Akin Elementary.

**Child Custody Issues**

The Akin Elementary Counselor does not make recommendations for custody of children in disputed cases. Such recommendations are beyond the scope of our services.

**Supervision Disclosure Statement and Recording Consent**

I understand that in addition to being a School Counselor, Resa Kay Jimenez is also a Licensed Professional Counselor Intern. She will be working towards becoming fully licensed within the state of Texas to practice outside of the school system as well. Due to this, she will be discussing counseling cases without using any identifying information. Only the situations and circumstances will be discussed within an education setting. All other information is kept strictly confidential.

The following three reasons are the only lawful reason to notify someone about what is said in counseling.

1. The student is hurting themselves.
2. The student is planning on hurting someone else. (plan, means, intent)
3. The student is currently being hurt and is in danger at that time.

**I understand that Resa Kay Jimenez is a fully credentialed School Counselor.**

**I understand that she will be under supervision by a fully licensed professional therapist. (LPC)**

**I give consent for my child to receive services from Resa Kay Jimenez and understand that she expects to stay in regular contact with the guardian throughout the school year.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Signature of Parent/ Legal Guardian Relationship to Child

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Student’s Printed Name Date



CONSENT FOR TREATMENT  
OF A MINOR

We/ I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent(s) and/ or   
legal guardian (s) of a minor child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,   
give you full authority to provide counseling services to my child.

This consent is given by me/ us parent(s) and/ or legal guardian(s) of the child   
listed above. We/ I have legal power to consent to counseling. It is clearly   
understood that you are hereby fully released from any claims and demands   
that might arise, related to the treatment provided that your duties are   
performed with standard care and responsibility to the best of your professional   
ability.

I give permission to discuss and receive reports from the teachers and   
administrators at Akin Elementary about the progress of the minor listed   
above. This will only be done when it benefits the child’s progress within   
the classroom and on our campus. This information will be limited to only   
the information required. I understand that this information will be kept on topics   
related to classroom behavior and success. Other topics will only be released   
according to the Akin Privacy Practices, which I have signed already.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature of Parent/ Legal Guardian Relationship to Minor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Student’s Printed Name Date