



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: _____ Grade: _____

Parent/Guardian name and preferred contact:

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 _____ Date of Birth ____/____/____