Chemical Abuse Prevention Program – Referral for Services and Parent Consent – 2016-2017

Leander Independent School District

Please note: Student's Campus Counselor or Assistant Principal Must Complete this Referral Form

Instructions: Check one or more of the following:

___30 Day Review for LEO?

___Screening for LEO Placement ONLY (Brief history of substance use) Check if student is going to LEO.

___Substance Abuse Assessment (Comprehensive evaluation of substance use/abuse–student & parent attend)

___Counseling (Brief or ongoing individual/group counseling with CAPP Counselor). **Have parent sign consent and attach to referral please.**

___Parent(s) were notified of referral for assessment or counseling.

___Parent(s) signed consent for counseling. (Attach consent with referral please.)

___Parent(s) were given Mary Ann Kluga's phone number (512-570-0315) to call and set up assessment.

___Placed copy of this referral (and consent) in CAPP counselor's campus mail box AND

___Emailed or faxed to: maryann.kluga@leanderisd.org or 570-1808 or x.11808

Date of referral: _____ Student ID#_____

Student's Name: _____

Address:_____ City_____

County: _____ Zip: _____ Hm. Ph. _____ Cell: _____

Parent email address:_____

School that student attends: _____ Grade: _____

Name of Assistant Principal or Counselor making referral: _____

Phone Number: _____

Name of student's primary caretaker, and relationship to student: _____

_____

Reason for Referral:

_____

_____

_____

_____

What professionals/agencies/ressources are already involved with this student/family?

☐ CPS ☐ Therapist ☐ Juvenile Probation ☐ FST ☐ Other

Are you aware of any recent significant family events/stressors (i.e., arrests, marriages, separations, divorces, births, death, lost job, financial issues, etc.?)

Please ask the student the following questions:

I. A. Do you believe you have a drug/alcohol problem? If yes, give explanation.

B. Do you want help?

II. A. Do you believe some of the problems you are experiencing are related to a family member's drug/alcohol abuse? If yes, explain.

B. Do you want help?

School Year 2016/2017

Dear Parent/Guardian,

Your child has expressed an interest in participating in a Life Skills Education Group provided by LISD's Chemical Abuse Prevention Program (CAPP). The individual/group sessions typically meet weekly/biweekly for approximately 30-45 minutes each time. Some students may only need/want counseling for a shorter length of time (i.e., 2-6 sessions). The sessions may focus on the following topics:

- Planning and Decision Making
- Assertiveness/Refusal Skills
- Self-esteem/Self-image
- Ethical Principles
- Issues concerning Substance Use/Abuse
- Peer Influence/Friendship Skills
- Building Positive Relationships
- Resolving Conflicts

In order to evaluate the effectiveness of our program, we will be administering pre and post surveys to our students to measure the skills that they have learned from attending our sessions.

Please sign and have your child return this form to the CAPP Counselor circled below. Your child may participate in our program as long as determined necessary by his/her CAPP Counselor.

If you have any questions, please call your child's CAPP Counselor. Thank you for your support.

Laura Zermeno	Sarah Romer	Lucy Dunnehoo	Angela Carey	Mary Ann Kluga
CAPP Counselor	CAPP Counselor	CAPP Counselor	CAPP Counselor	CAPP Coordinator
512-570-0316	512-570-0317	512-570-0318	512-570-0339	512-570-0315

_____

I, _____, give permission for my child

_____, to participate in this guidance class and to

complete the pre/post surveys.

_____ _____ _____

Parent/Guardian Signature Phone Number Date

_____ _____

Student's Full Name Student's Campus