

**Our Lady of the Gulf Catholic School - Referral for Counseling Form**

Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Name of Parent Requesting Referral: \_\_\_\_\_

Parents' Comments:

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Permission for student to meet with School Counselor during school hours:

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Parent's Signature/Date

Permission for school/counselor to contact student's medical doctor or other therapists working with the child pertaining to above reasons listed.

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Parent's Signature/Date