1. Each student participating will complete a brief questionnaire about their health, feelings, and behaviors.
2. Next, each student will meet individually with one of our program staff to talk about their screening results.
3. If a student is identified as having any concerns or needs, our staff may contact the student’s parent/guardian to discuss the screening results and recommend further evaluation.

For a more detailed description of the Youth Screen Program, see next page.

We help connect families to outside services for those who are interested.

Please complete and return the attached parent consent form(s) to let us know if your child will be participating or not.
Youth Screen Parent Consent Letter

Dear Parents/Guardians,

As parents you are well aware that the physical and mental health of young people plays a key role in their ability to succeed in school, have rewarding relationships with family members and friends, and lead productive and happy lives. The Youth Screen program is committed to working with you to ensure that they reach their full potential outside of the classroom. To that end, we are offering parents of 6th-9th grade students at East and North Rockford middle school, as well as the Freshmen center, the opportunity to have their teens participate in the Youth Screen Program in the month of March. Youth Screen is a program designed to identify risk factors associated with depression, anxiety, and alcohol and substance abuse. Youth screen is not a diagnostic tool. The program is free to students, completely voluntary, and confidential.

The teen years are a time of tremendous change. Youth Screen can help parents better understand the changes their teens are experiencing. For most parents, this screening will reassure you that your teen is just experiencing typical “growing pains.” For other parents, Youth Screen can help you pinpoint a problem in its early stages; giving you the ability to secure needed help for your teen and reduce the chance that a more significant problem will develop in the future.

I hope you will take advantage of this confidential screening for your teen. Please read the information below, and then sign and return the Parent Consent Form on the next page to indicate whether you want your teen to participate.

How Does Youth Screen Work?
The Youth Screen Program is run by Family Outreach Center, a local non-profit mental health agency. It will take place at the school, during school hours in a private setting at the school. Your teen will not be screened without your permission. All screening results will be kept confidential, stored separately from academic records at the Family Outreach Center office, and not shared with your teen’s teachers. There are three steps to the screening procedure:

**Step One:** Teens complete a 10-minute questionnaire about vision, hearing and dental problems, symptoms of depression and anxiety, suicidal thinking and behavior, and use of drugs and alcohol.

**Step Two:** Teens whose answers reveal a potential problem and teens who ask for help then meet with a trained mental health professional in private to determine if further evaluation would be helpful. Teens whose answers show they probably do not need help meet briefly with other program staff to answer any questions they may have about the program and to give them the opportunity to ask for help with any other concerns the screening did not cover. This is also an opportunity for teens to provide valuable feedback about the program to program staff.

**Step Three:** You will be contacted by program staff only if your teen meets with a mental health professional and the professional recommends further evaluation for your teen. If this is the case, program staff will share the overall results with you and discuss ways you can get help for your teen. You will not be contacted if your teen is not found to need additional mental health services. If a vision, hearing or dental need is identified during the screening process, program staff will inform you by a letter sent to your home.

Family Outreach Center provides this screening at no cost, but does not provide further evaluation or treatment services. It is up to you to decide if you want to obtain any additional services for your teen. **Please do not hesitate to call Kim Scherencel at 616-988-1479 if you have any questions.**

Sincerely,

Kim Scherencel, LMSW – Youth Screen Program Coordinator/Supervisor
Family Outreach Center
255 Colrain St SW, Wyoming, MI 49548
Youth Screen Parent Consent Form

Please have your child return this form to the school guidance office by the following deadlines:

** NRMS Deadline March 5 **

I have read and understand the description of the Youth Screen Program offered at Rockford schools:

____ Yes, I would like my child to participate in the Youth Screen Program ** (Please also see the back of this form regarding the option of sharing the screening information with the school) **

____ No, I do not want my child to participate in the Youth Screen Program

Parent/Legal Guardian’s Name (Print): ______________________________________

Student’s Name (Print): ______________________________ Grade: _____________

Parent/Legal Guardian’s Signature: _________________________________________

Date: __________

If your child will be participating, please provide the following information so we can contact you if necessary:

Address: ______________________________ Home Tel. #: __________________

________________________________ Cell Phone #: __________________

Best times to reach you:

1) ______________________________ Tel.#: __________________

2) ______________________________ Tel.#: __________________
AUTHORIZATION FOR RELEASE OF INFORMATION FROM THE RECORD OF:

Name: ___________________________________________ Date of Birth: _________________________

Last First Middle
I hereby authorize: Youth Screen Staff Clincian

Name of Individual Position

FAMILY OUTREACH CENTER 255 Colrain St SW STE 2, Wyoming, MI 49548

Agency/Organization Complete Address

To [X] Exchange [ ] Release specific information from my record to: 

Name of Individual: School Counselor/Social Worker; Principal

Rockford school of present attendance (North, East, Freshmen Center)

Agency/Organization Complete Address

The information to be released is limited to the following records specified by description and date, and may include information about drug/alcohol usage, if applicable.

The information to be released is to be used ONLY for the following authorized purpose:

Results of youth screen specifically for follow up recommendations.

This authorization is effective only for the following period of time (not to exceed one year).

From: March 2018 To: June 15th 2018

My authorization is withdrawn if any of the following occur:

Event: End of school year
Condition: Verbal or Written request

I understand that I may withdraw this release at any time by notifying the agency holding my records.

Signature: ___________________________________ Date: ___________________

Client or Legal Guardian/Parent of Minor

Release obtained by: __________________________ Date: ___________________

Signature of Witness

Further release of information disclosed by the above authorization is prohibited by the Michigan Mental Health Code and the Federal regulations governing disclosure of Substance Abuse records. This means that the released information may not be copied, shared, or released except as consistent with the authorization purpose stated above. This release is in compliance with Title 42 of the Code of Federal Regulations, Part II which also prohibits re-disclosure.