Student Outreach Services (SOS)

Student/Parent Contract

Student Name: _____ **DOB:** _____

Parent/Guardian: _____ **Phone:** _____

School: _____ **Grade:** _____ **ESE: Y / N (circle one)**

Referral Source: ☐ **School** ☐ **SERT** ☐ **TURN** ☐ **DJJ**

School/Agency Contact: _____ **Phone:** _____

Your child has been recommended to participate in the **SOS** program for the following offense:

_____

CRITERIA FOR SUCCESSFUL COMPLETION:

1. Parent and student meets with the substance abuse therapist (approximately 2 hours) to sign consents and to complete a substance abuse assessment and drug test. Parent must call the Charlotte Behavioral Health Care screener at 941-347-6437 to schedule the appointment within 3 working days of the dated contract _____.

2. Student participates in the following, based on the assessment results:
   a. Group sessions (up to 12) and/or
   b. Individual and family counseling with the substance abuse therapist.

3. Parent and student meet with the substance abuse therapist at the conclusion of the counseling sessions for a review of program participation outcomes and recommendations.

Failure to complete all assigned requirements may result in further disciplinary action, including a recommendation for expulsion for school referrals.

I have reviewed the above program requirements and _____ **agree** _____ **do not agree** to participate in the **SOS** Program. I understand that any costs for these program services will be my responsibility.

_____ _____

Parent/ Guardian Signature Date Student Signature Date

Fax to: 255-7483 Intervention and Dropout Prevention Services Office
Original: School/Agency Referral Source
Copy: Parent

Revised 3/2016