Bi-County Collaborative
Making It Possible

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CLINICAL EVALUATION PARENT PERMISSION FORM

Student Name _____ ***Date*** _____

I give my permission for my son/daughter to be evaluated for risk by the Bi-County Collaborative consulting psychologist.

Signature _____

I give my permission for my son/daughter to have a complete psychological evaluation by the Bi-County Collaborative consulting psychologist.

Signature _____

I give my permission for my son/daughter to have an evaluation by the Bi-County Collaborative consulting psychiatrist.

Signature _____