

**PARENT CONSENT FORM**

**Department of Human Development and Psychological Counseling**

**APPALACHIAN STATE UNIVERSITY**

Parent's name

\_\_\_\_\_

Address

\_\_\_\_\_

Phone \_\_\_\_\_ (Home) \_\_\_\_\_ (Office)

The Department of Human Development and Psychological Counseling at Appalachian State University conducts Clinical Mental Health Counseling Practicum/Internship each semester. The Community Counseling Practicum/Internship is an advanced course in Community Counseling required of all Master's degree candidates in the Community Counseling Program at Appalachian State University. Students are required to audio- and/or videotape counseling sessions as part of their course and degree requirements.

I (student counselor's name) \_\_\_\_\_ would like to work with your son/daughter, at (name of agency or school) \_\_\_\_\_  
\_\_\_\_\_.

The counseling sessions conducted with your child will be audio- and/or videotaped and will be reviewed by the student's supervisor. All audio- and videotapes made will be erased at the completion of your child's involvement in the program.

We hope that you will take the opportunity to have your child become involved in the Clinical Mental Health Counseling Program. If you are interested in having your child participate, please sign the form where indicated.

Thank you for your cooperation.

Parent's signature \_\_\_\_\_ Date \_\_\_\_\_

Counselor's signature \_\_\_\_\_ Date \_\_\_\_\_