S.N.A.P.

Student Needs Assistance Program

EASTERN YORK HIGH SCHOOL
P. O. BOX 2002
WRIGHTSVILLE, PA 17368-0200
717-252-1551

Student Name:_____

Reason for Evaluation:_____

_____

_____

As the parent(s)/guardian(s) of the above mentioned student, I/we hereby give permission to Eastern York High School S.N.A.P. Team to refer my/our child for the appropriate evaluations as specified above to aid the school district to better understand the needs of my/our child. I/we understand that we will be contacted by the S.N.A.P. Counselor to discuss the counseling evaluation.

I/we hereby give permission to Eastern York School District to release information about my/our child to True North Wellness Services. This information may include educational, medical, psychological, and social data which might be helpful to further study and understand the student.

Approve _____ Do not approve _____

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Team Members Signature Date