**CLACKAMAS COUNTY BEHAVIORAL HEALTH DIVISION**

**CONSENT FOR CLACKAMAS WRAPAROUND INTAKE SCREENING:**

Name of Child:      ­       DOB:

First Last

Name of Parent(s)/Guardian:

Address:       Phone: (     )      -

City:       State: OR Zipcode:

I understand that my child has been referred to Clackamas Wraparound. An intake screening needs to be conducted to determine eligibility. Clackamas Wraparound requires a comprehensive review of needs, supports, systems involvement (to name a few), which may include a review of records from involved agencies and systems. This helps the Committee to determine if the Wraparound process is appropriate. I understand that all information will be kept completely confidential, unless I sign an Authorization to Disclose Information form.

I understand that participation Clackamas Wraparound is voluntary and hereby give my permission for my child to participate in the Clackamas Wraparound intake screening to determine Clackamas Wraparound eligibility.

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# Signature of Parent/Guardian Date