

**Crown of Life Christian Academy**  
**535 Berea Street**  
**Fort Atkinson, WI 53538**  
**920-563-2278**  
[www.crownoflifeacademy.org](http://www.crownoflifeacademy.org)

**PERMISSION TO MEET WITH MENTAL HEALTH SUPPORT SPECIALIST**

In order for your child to receive Support Services from Mr. Bret Skaer, we will need your written permission so that your son/daughter may leave the classroom. After an individual session, Mr. Skaer will contact you for an update.

Please complete the portion below and return this form to your son/daughter's teacher. If you have any questions, please contact



Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Date: \_\_\_\_\_

- Parent                       Legal Guardian                       Legal Authority

Authorized Signature \_\_\_\_\_ Date: \_\_\_\_\_

- Parent                       Legal Guardian                       Legal Authority

\* This permission is valid for one year from the date of signing. A copy of this form is as valid as the original.

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