**CYMH Consultation & Collaboration (CYMH CC)**

**Confirmation of Community Agency Support**

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| --- | --- | --- | --- |
| To: |  | | |
| From: |  | School: |  |
| Student: |  | DOB: |  |

***The Ministry of Education requires written confirmation of support for students claimed within the Intensive Behaviour Category.***

**Name of Service Provider/Agency:** Consultation & Collaboration - Child & Youth Mental Health Clinician

**Date Support Begins:**

**Support Provided:** Shared planning based on student profile.

**Frequency:** Bi-annual consultation and collaboration.

**Comments or suggestions to support programming:**

See SD61 Consultation and Collaborative Shared Planning and Meeting Notes

Any additional comments or suggestions to support programming:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Professional/Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_