

## COUNSELING

The counseling services component offers students the opportunity to receive individual, family, and group counseling with a Master's Level Clinical Counselor. The counseling services component focuses on all issues related to student health and emotional well being and offers school-wide programs that raise awareness of resources related to well being. Additional services include social needs assessments, substance abuse referrals, and referrals to public welfare agencies, social and service organizations, and local mental health providers as necessary.

## YOUTH DEVELOPMENT

The Youth Development component offers activities that focus on building self esteem, developing positive relationships, reducing teen violence, and helping youth cope positively with peer pressure. Specific group activities are planned to foster responsible citizenship and leadership. Recreational activities, student projects, youth study field trips, and college visits/tours are also coordinated.

## HEALTH EDUCATION

The Health Education component offers activities that focus on health relationships, birth control and abstinence, education on sexually transmitted infections, and goal setting and pregnancy prevention. Specific individual and group activities are planned to address the needs of both male and female groups and are created with the input of students and school staff.



Making Visions Possible 2017 | www.mvp-whs.org | (609) 835-8800 Ext. 3051



MVP

Contact us at:



*Making Visions Possible*



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MVP is a DCF Funded Program  
For more information, please visit:  
[www.nj.gov/dcf/families/school/](http://www.nj.gov/dcf/families/school/)

## ABOUT

Making Visions Possible or MVP is a state sponsored School Based Youth Services Program, which empowers students to complete their education, obtain skills leading to employment, remain mentally and physically healthy, as well as drug-free. All employment, health, social, and recreational services are provided at Willingboro High School, in partnership with the Center for Family Guidance, P.C. (CFG) and Willingboro Township Schools.

## PROGRAMS/SERVICES

Would you like for your son/daughter to participate in a specific program/service, please check all that apply:

- Mental Health & Family Support
- Individual / Group Counseling
- Case Management
- Healthy Youth Development
- College / Career Preparation
- Recreation (during open lunches & afterschool)
- Homework / Tutoring Services
- Volunteer / Community Service
- Health Education
- Substance Abuse Counseling / Prevention
- Pregnancy Prevention / Intervention (Male & Female Programs)
- Other: \_\_\_\_\_

I do not want my child to receive the following services, Please specify:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Consent of Liability

To participate in activities and services provided by MVP, Center for Family Guidance. I also acknowledge that my child's treatment information may be shared with school personnel and MVP staff if necessary for additional treatment.

I will assume absolute responsibility for my child's behavior and observance of safety rules while participating in all activities. It is my understanding that proper conduct applies at all times.

I understand that every attempt will be made to contact me and/or the authorized individuals listed in the event of an accident or injury. If it is impossible to contact me or these persons to authorize any emergency treatment, if deemed necessary by an attending physician, I hereby authorize treatment to be given.

- Is your son/daughter currently taking medication or receiving treatment for a medical/mental health condition?: Yes or No (circle one)  
If yes, please list condition and medication:  
\_\_\_\_\_
- Is your son/daughter supported by other State of New Jersey services?: Yes or No (circle one)  
If yes, please specify:  
\_\_\_\_\_

### Video / Photo Release (optional - please initial)

\_\_\_\_\_ I give consent for my child to have their video/photo taken for MVP related purposes.

\_\_\_\_\_ I have read the above and agree to its contents and further agree to absolve MVP, CFG, and its managing agencies of any and all liability.

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Parent/Guardian

If applicable, please check all that apply:

- Juvenile Justice
- DCP&P
- Foster Care Placement
- Free / Reduced Lunch
- Child Study Team

## Student/Parent/Guardian Information

### Student Information

(Please print and complete fully)

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_\_\_ Current Grade: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Medical Insurance Provider: (if applicable)

\_\_\_\_\_  
\_\_\_\_\_

### Parent/Guardian & Emergency Contact

Full Name (Parent/Guardian):

\_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

2<sup>nd</sup> Contact Name: (if applicable)

\_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_