



Consent for Treatment of Minors

NAME OF MINOR: _____

DATE OF BIRTH: _____

COUNSELOR: _____

This is to certify that I give permission to the Counselor listed above for treatment of my child. This treatment may include individual, family, and group psychotherapy and/or testing.

This treatment may include consultations with others in the helping professions, including but not limited to medical doctors, psychologists, school counselors, and teachers.

California State law mandates the reporting of certain types of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agency.

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian

Witness/Title

Street Address

City State Zip