Consent for Treatment of Minors

NAME OF CHILD ______________________________

DATE OF BIRTH ___/___/______

COUNSELOR _________________________

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

This treatment may include consultations with other associates including teachers, educational psychologists, school counselors, or doctors.

California 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. This treatment may also include referral to other appropriate state and county agencies for further counseling.

____________________________________ ____/____/______
Signature of Parent / Guardian Date

____________________________________ _______________________
Printed Name of Parent / Guardian Witness / Title

____
Street Address

____
City, State, and Zip