



# Consent for Treatment of Minors

**(re) defining culture's  
definition of health**

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NAME OF MINOR: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Clinician: \_\_\_\_\_

This is to certify that I give permission to \_\_\_\_\_ 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, and psychological abuse; reporting of emotional abuse is optional. 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

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

\_\_\_\_\_  
City State Zip