Consent for Treatment of Minors

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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