MINOR CONSENT TO COUNSELING

As a parent or legal guardian of ______________________________________ , I
(Child's Name)

authorize he/ she to be evaluated/ treated by ____________________________ .
(Therapist's Name)

As a parent or legal guardian, I have the right to request information concerning the above minor's evaluation and treatment.

Child's Full Name: ____

Child's Birth Date: _________________________

Today's Date: ___________________________

Signed: ___________________________________
Parent or Guardian (Please circle one)

Witnessed: ________________________________

STILL WATERS MINISTRIES
Conestoga Mennonite Church