CANTERBURY COUNSELING CENTER

CONSENT FOR TREATMENT OF MINORS

Client name ____

Date of Birth ____

Counselor(s) ____

This document certifies that I give my permission to CANTERBURY COUNSELING CENTER and the counselor listed above for treatment of my child. This treatment may include individual or group psychotherapy, counseling and testing. This treatment may include consultation with other associates of this institution. This treatment may also include referrals to other appropriate state and county or professional agencies for further counseling.

____ ___________________________

Signature of Parent/Guardian Date

____

Printed Name of Parent/Guardian

____

Street Address

____

City/State/Zip

____

Phone

____

Witness / Title