PERMISSION TO TREAT MINOR CHILD

PARENTS/GUARDIANS:

Mother Father Step Parent Other

Name ____

Address ____

____

Phone ____

Permission to Share Information with above: Yes No Yes No
(by Law Information cannot be withheld from bio parents)

DEVELOPMENTAL HISTORY:

Gestation (Any used): Drugs Medications Alcohol Cigarettes

Complications/Difficulties____

Labor/Delivery: C-Section Vaginal Premature Full Term Gestational Age: __________

Complications/Difficulties: ____

Developmental Milestones: Early On Schedule Late

Difficulties: ____

Infant Behavior:____

Toddler Behavior:____

Childhood Experiences:____

Adolescent Experience____

By my signature below, I give consent for my minor child to receive treatment at JM Counseling, Inc. I understand that at times I may be asked to participate in a session. I further understand that due to the delicate balance of trust between patient and therapist it is necessary to create privacy for my minor child. I have been made aware of the exceptions to privacy and that I can request general progress updates at any time.

____________________________________ ____________________

Parent/Guardian Signature Date