PERMISSION TO TREAT MINOR CHILD

----------This Page is for Information on Minors Only---------

PARENT CONSENT:

By my signature below, I give consent for my child to receive treatment at JM Counseling Center.

Parent/Guardian signature _____

PARENT/GUARDIAN:

	Mother	Father	Step Parent	Other
Name	_____	_____	_____	_____
Address	_____	_____	_____	_____
Phone	_____	_____	_____	_____

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

DEVELOPMENTAL HISTORY: (please be as complete as possible)

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: _____


JM Counseling
Helping on Your Journey