

Claremont Counseling and Support Center
www.claremontcounseling.com
250 W. First Street, Suite 230
Claremont, CA 91711
909-624-1997
909-624-4409 fax number

Consent for Treatment of Minors

Name _____
Date of Birth _____
Counselor _____

This is to certify that I give permission to Claremont Counseling and Support 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 consultations with other Claremont Counseling and Support Center Associates including Psychologists, MFT s, MFT Interns, Career Counselors or Nutritionists.

California State Law mandates the reporting of certain types of child abuse, including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agency.

This treatment may also include referral to other appropriate State and County agencies for further counseling.

Signature of Parent/Guardian Date

Printed Name of Parent/Guardian Witness/Title

Street Address

City State Zip Code

(_____) _____
Phone Number