



Christian Life Fellowship
Counseling Ministry
Consent For Counseling Minors

Name of Parent/Guardian _____

Name of Minor _____

Minor's Date of Birth _____

Are you divorced or have legal guardianship of this child? ___ Yes ___ No

If yes please answer the next question.

I have provided Christian Life Fellowship Counseling Ministry with a copy of the divorce decree or guardianship form?

___ Yes ___ No

This is to certify that I give permission to Christian Life Fellowship Counseling Ministry for treatment of my child.

This counseling may include individual or family psychotherapy, counseling, and testing.

This counseling may include consultations with other associates of this institution.

This counseling may also include referrals to other appropriate state and county or professional agencies for further consultation, if necessary.

Signature of Parent/Guardian Date

Signature of Parent/Guardian/Custodial Parent Date

Street Address _____

City/State/Zip _____

Home Phone _____ Work Phone _____

Emergency Contact (Other than yourself):
Name _____ Phone _____

Signature of Witness/Title/Date