

ALISSA SHELDON, PH.D., PLLC.
601 North Flamingo Road, Ste. 213
Pembroke Pines, FL 33028

Phone: (954) 659-0115

Fax: (954) 659-0665

CONSENT FOR TREATMENT OF A MINOR

We/I, the undersigned _____, parent(s) and/or guardian(s) of a minor child _____, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.

Signed this ____ day of _____, 20__

Mother or Guardian

Father or Guardian

The above explained to: (circle all that apply) Mother / Father / Guardian

By _____ on the ____ day of _____, 20__

Witness

Date