CONSENT FOR TREATMENT OF MINOR CHILD

In order that my child may have the benefit of all counseling, psychological and social services

provided by Breakthrough Counseling, KC:

1) I hereby consent to his/her participation in the diagnostic treatment/education

programs which are deemed professionally necessary for appropriate service;

2) I acknowledge that I am responsible for my child during his/her/their treatment sessions.

I will not leave my child unsupervised anywhere on the premises and I will not leave the premises while my child is on site. I understand that no child will be left in the waiting room or other areas unsupervised while I am attending an agency meeting, function or session.

3) I acknowledge that I am the legal guardian of this child.

Parents may be asked to remove their child from our premises or the local authorities may be called for assistance if minor becomes a risk to self or others.

Name of Child _____

Print name

Parent or Legal Guardian _____ _____

Print name Date

Parent or Legal Guardian Signature _____ _____

Date