

CONSENT FOR COUNSELING OF MINORS

Name of Parent/Guardian _____

Name of Minor _____

Minor's Date of Birth _____ Name of Counselor(s) _____

This is to certify that I give permission for the minor named above to participate in the therapeutic counseling group _____ offered by HopeWorks Counseling and scheduled to start on the _____ of _____, 200____.

Signature of Parent/Guardian _____ Date _____

Printed Name of Parent/Guardian _____

Street Address _____

City/State/Zip _____

Home Phone _____ Work Phone _____

Emergency Contact (Other than yourself) _____ Ph. _____