a place to turn...and beyond
Center for Therapy, Health, and Wellness
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CONSENT FOR TREATMENT OF A MINOR

TO WHOM IT MAY CONCERN:

As the parent(s)/guardian(s) of: _____

_____

_____

_____

I/We consent to the treatment of the above listed minor (s) by A Place to Turn, Inc., as well as any medical treatment or hospital services that may be necessary.

This consent shall remain in effect until revoked in writing.

_____ _____
Parent/Guardian Name **Phone Number**

_____
Address

_____ _____
Parent/Guardian Signature **DATE**

_____ _____
Parent/Guardian Name **Phone Number**

_____
Address

_____ _____
Parent/Guardian Signature **DATE**

_____ _____
Therapist Signature **DATE**