FORENSIC COUNSELING SERVICES

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Program Director

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CONSENT FOR TREATMENT OF MINOR(S)

We/I, the undersigned parent(s), legal conservator(s), and/or guardian(s) of minor child(ren)

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

hereby give full and unconditional authority for Dr. Robb to proceed with clinical evaluation and treatment of my/our minor child as his professional judgment indicates.

This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal authority 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 Dr. Robb's duties are performed with standard care and responsibility to the best of his professional ability.

_____	_____	_____
Parent or Guardian Signature	Printed Name	Date
_____	_____	_____
Parent or Guardian Signature	Printed Name	Date

If this form is completed by only one parent or guardian, please provide the following information regarding the child's other parent(s) or guardian(s):

Name:	Parents' Marital Status (Circle One) Divorced / Married / Never Married
Address:	Cell Phone No.