Carol Rose Adkisson
www.caroladkisson.com
9161 Sierra Ave. Suite 213, Fontana, CA 92335
909-693-3177

Consent for Treatment of Minors

Name _____
Date of Birth _____
Counselor _____

This is to certify that I give permission to Carol Rose Adkisson, LMFT #83484 and the counselor listed above for treatment of my child.

This treatment may include individual or group psychotherapy, counseling, and testing. This treatment may include consultations with other Carol Rose Adkisson, LMFT including Psychologists, MFT's, MFT Interns, MSW and MSW Interns.

California State Law mandates the reporting of certain types of child abuse, including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agency.

This treatment may also include referral to other appropriate State and County agencies for further counseling.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Printed Name of Parent/Guardian Date

_____
Street Address

_____
City/State/Zipcode

( )
Phone Number