

Authorization To Treat A Minor (under 18)

I, \_\_\_\_\_, Parent/Legal guardian of \_\_\_\_\_  
(Name of parent/legal guardian) (Name of Child)

\_\_\_\_\_ give my permission for him/her to be seen at the Covenant family Services, for the purposes of  
(Date of Birth)

evaluation and treatment

\_\_\_\_\_  
Signature of parent/legal guardian

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Date

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Witness Signature

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Witness Name Printed