Sheryl A. Isaacs MS, LMFT
Licensed Marriage and Family Therapist #92577
5523 Scotts Valley Drive, Scotts Valley, CA 95066
831-431-7996

www.therapyforyourchild.com

CONSENT FOR TREATMENT OF A MINOR

Child's Full Legal

Name:____ Child's Date of Birth:________________

Name and ages of siblings:____

Mother's Name: ____

Father's Name: ____

Status of parents:

□Married □ Unmarried □ Separated □ Divorced □Widowed

If separated, divorced or unmarried who has custody of minor child?

□Father □Mother □Joint Custody

Custody Schedule of Visitation/Shared Custody:

____
____
____
____

Mother's Contact Information

Home Address:

Street____City______________________ State____

Home phone:___________________ Cell Phone: _________________Work Phone: ___________________

Email Address: ____

Messages may be left at: □Home □Cell □Work □Email

Father's Contact Information

Home Address:
Street____City___________________________ State____
Home phone:________________ Cell Phone: ________________ Work Phone: _______________________

Email Address: ____

Sheryl A. Isaacs MS, LMFT
Licensed Marriage and Family Therapist #92577
5523 Scotts Valley Drive, Scotts Valley, CA 95066
831-431-7996

www.therapyforyourchild.com

Messages may be left at: □Home □Cell □Work □Email

For the health and well-being of your child and others, do not bring your child to therapy if they are experiencing a fever of other contagious childhood illness. If you are concerned that your child is becoming sick it would be best to keep them home. Please call and notify the therapist that your child will be missing therapy.

This is to certify that I give permission to Sheryl A. Isaacs to provide psychotherapy to the child named below. I understand that the therapist may need to consult with other involved professionals on order to fully assess the needs of this child. At such time, I will sign the appropriate release forms necessary to obtain this information.

Child's Name: ____

Mother's Signature: ____

Date: _________________________________

Father's Signature: ____

Date: _________________________________

Child Custody Agreement Received

Date: _________________________