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: _____

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

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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 group 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: _____