WASHINGTON NUTRITION & COUNSELING GROUP™

CONSENT TO TREATMENT MINOR

Name of Minor:	
Age:	
Date of Birth:	

I, _____, am the legal custodian of the above named minor.

Please check one:

	I have full legal authority to consent to treatment of the minor without obtaining consent or approval of another person.
	I have joint custody of the minor pursuant to a decree that requires both my consent and the consent of another person.

I hereby authorize Washington Nutrition & Counseling Group to provide counseling to the minor in connection with substance abuse, mental health and/or other personal problems.

_____

Name of Parent or Legal Guardian signing this form (please print)

_____

X Signature of Parent or Legal Guardian

_____

Date

_____

Witness