Parental Permission to Treat a Minor

Kanawha Pastoral Counseling Center
16 Leon Sullivan Way, Suite 300
Charleston, WV 25301
304-346-9689 www.kpcc.com

Client Name: _____

Date: _____

I hereby give permission for (child's name) _____

my (child, ward, etc.) _____, who is _____ years old, for counseling at KPCC.

1. I hereby verify that I have the legal right to bring this child for counseling. Initial: _____
2. If child's parents live separately, or are divorced, I verify that I have sole/joint (circle) decision making responsibility for my child's emotional/mental/medical health care. Initial: _____
3. If the court order does not specify sole responsibility for regular (non-emergency) medical treatment, this form must be signed by both parents.
4. I understand that the therapist will likely contact both parents to gather information and to discuss treatment options.
5. I understand that all consultation between the above-named child/client and the therapist shall be held in strictest confidence. I will not ask the child/client or the therapist to divulge the contents of their conversations.
6. I may ask to be included in a joint session with the therapist and the child/client if I have any concerns which I wish to share with either of them.
7. I may also ask to meet individually with the therapist to discuss issues related to my parenting of my child.
8. Anything I choose to share with the therapist about the child/client by phone or otherwise may be communicated to the child/client by the therapist.
9. I understand that if the child/client poses a threat to the physical well-being of him/herself or others the therapist will inform me of the danger. I understand that if the therapist has a reason to suspect neglect or abuse of my child, the therapist is obligated to report this to Child Protective Services.

_____ _____ ____/____/____
Signature of Mother or Guardian 1 Phone Date

_____ _____ ____/____/____
Signature of Father or Guardian 2 Phone Date

Statement of Confidentiality

Maintaining confidentiality is very important to us at Kanawha Pastoral Counseling Center. No information about you will be released to other parties without your written permission. Limited information will be released to your insurance company as required.

We make every effort to protect your privacy; however, there are three occasions in which all therapists are mandated by law to break confidentiality.

1) If a client indicates he/she is considering suicide the therapist will take necessary action to help ensure the client's safety. If the client is a minor, his/her parent or guardian will be involved in the arrangement.

2) If a client indicates he/she is planning to harm another person, the therapist will notify the proper authorities and/or the intended victim. If the client is a minor, the parent or guardian will be involved.

3) If a client indicates he/she has knowledge of the abuse or neglect of a child, an elderly person, or a person who is mentally or physically impaired, Child or Adult Protective Services will be contacted. This may also be done without your consent or knowledge.

By signing below, I acknowledge the statement of confidentiality and agree to the above.

_____

Client/Guardian Date

_____

Client/Guardian Date

_____

Client/Guardian Date

_____

Therapist Date

Symptom Checklist- Under 18

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Name _____

Date _____/_____/_____

Please ***check*** all that apply and ***circle*** specific items in parentheses.

____ ***School Problems*** (frequent absences, poor grades, refusal to go, gets in trouble, doesn't do homework, suspended, disorganized, fights)

____ ***Drug Use*** (alcohol, cigarettes, marijuana, LSD, cocaine, other)

____ ***Abused by*** (physical, sexual, verbal) (parent, boyfriend/girlfriend, relative, other)

____ ***Depressed*** (crying, sadness, tired, sleeps a lot, can't sleep, grumpy, withdraws)

____ ***Parents*** (divorced, separated, argue)

____ ***Parent Problems*** (don't get along with, little contact, don't like partner/spouse, too strict)

____ ***Attention*** (Doesn't: listen, finish projects, organize, is: forgetful, distracted, easy mistakes)

____ ***Hyperactive*** (fidgety with hands or feet, talks a lot, can't sit still, interrupts)

____ ***Anxiety*** (nail-biting, crying, headaches, pulls hair, nervous body movements)

____ ***Fears*** (of _____)

____ ***Stress*** (school, parents, grades, schedules, step-parent, other)

____ ***Eating Disturbances*** (overeating, not eating, vomiting, bingeing)

____ ***Suicide*** (attempt, gesture, threat, warning signs)

____ ***Self-Harming Behaviors*** (cutting, body piercing, burning)

____ ***Behavior/Acting Out*** (argues, quick temper, not listening, breaking curfew, ignores rules)

____ ***Aggression with*** (animals, siblings, parents, peers)

____ ***Broken Laws*** (theft, weapons, fire setting, runaway, breaking in, destruction of property)

____ ***Self-Esteem Low*** (with friends, school, family, job, boy/girlfriend)

____ ***Compulsive Behaviors*** (excessive washing of hands, checking things, worrying)

____ ***Pregnancy*** (current, previous, has a child, miscarriage)

____ ***Trauma*** (death of someone, date rape, rape, car accident, other

____ ***Sexuality*** (dating relations, excessive curiosity by a child, acting out, STD's)

____ ***Wetting or soiling*** self

____ ***Sleep Disturbances*** (nightmares, falling sleep, sleeps too much, restless)