

I give my permission for \_\_\_\_\_ to be seen by  
(Minor's Name)

\_\_\_\_\_ of Central College Christian Counseling.  
(Clinician's Name)

\_\_\_\_\_  
(Printed name of Parent/Guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Phone)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Date)