SANTIAGO CANYON COLLEGE
HEALTH AND WELLNESS CENTER
PSYCHOLOGICAL SERVICES

Psychological Services
Consent For Treatment
Of Minor

I hereby consent to and authorize the utilization of psychological services for my son/daughter. Such services may include assessment and treatment procedures deemed necessary by the treating clinical psychologist.

______________________________	______________________________
(Print Name)	**(Print Parent's or Legal Guardian's Name)**
______________________________	______________________________
(Student Perm. Number)	**(Address)**
______________________________	______________________________
(Social Security Number)	**City, Zip**
______________________________	______________________________
(Birth date)	**Work Phone**

____________________	______________________________
Date	**Signature**
	______________________________
	Relationship
____________________	______________________________
Date	**Witness**