KALON
CHRISTIAN COUNSELING

Consent for the Counseling of Minors (Age 17 and under)

Name of Parent/Guardian: _____

Name of Minor _____

Minor's Date of Birth _____ Name of Counselor _____

This is to certify that I give permission for the minor named above to participate in counseling offered by Kalon Christian Counseling.

Signature of Parent/Guardian _____ Date _____

Printed Name of Parent/Guardian _____

Street Address _____

City/State/Zip _____

Home Phone _____ Work/Cell Phone _____

Emergency Contact (other than yourself) _____ Phone _____