Grief Recovery Center
4939 Jamestown Ave., Suite 101
Baton Rouge, LA 70808
Phone: (225) 924-6621 Fax (225)924-6627

CONSENT TO TREAT FORM FOR MINORS

Child's Name: _____
Last First Middle

Child's Address: _____
Street Address Apt. #

City_____State_____ Zip_____

Name of School Attending: _____ Grade: _____

Parents are: ___ Married; ___ Divorced; ___ Never Married; ___ Deceased (Circle One: Mother, Father, Both); ___Domestic Partnership; ___ Parental Rights Terminated (Circle One: Mother, Father, Both)

******Divorced Parents and Guardians Must Attach The Most Recent Court Judgment******

Mother's/Guardian's Information

Name: _____
Last First Middle

Address (If Different from Child): _____
Street Address Apt. #

City_____ State_____ Zip_____

Phone: H(___) _____ W(___) _____ C(___) _____

Employer: _____Phone #_____

Father's Information

Name: _____
Last First Middle

Address (If Different from Child): _____
Street Address Apt. #

City_____ State_____ Zip_____

Phone: H(___) _____ W(___) _____ C(___) _____

Employer: _____Phone #_____

I hereby authorize the Grief Recovery Center to treat the above-named child and further I attest that I have the legal right to make this authorization.

Parent/Guardian Signature:_____ Date:_____

Office Use: Administrative – Release – Parent/Guardian