



Shelby Wellness & Therapy Center, PLLC  
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## CONSENT FOR TREATMENT OF A MINOR

We/I, the parent(s) and/or guardian(s) of the minor child, \_\_\_\_\_ ,  
give you full and unconditional authority to proceed with a clinical evaluation and treatment as  
your judgement indicates. This consent is given by me/us as parent(s) and/or guardian(s) of  
said child.

We/I have legal power to consent to medical, psychological, and mental health assessments  
and treatments of said minor child. It is clearly understood that you are hereby fully released  
from any claims and demands that might arise, or be incident to the evaluation and/or  
treatment, provided that your duties are performed with standard care and responsibility to  
the best of your professional ability.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship \_\_\_\_\_

Signature of Staff Witness \_\_\_\_\_ Date \_\_\_\_\_