Parental Consent for Treatment of a Minor
Kennesaw State University
Counseling & Psychological Services

I hereby give consent for Kennesaw State University Counseling & Psychological Services to provide individual counseling, group counseling, and/or psychiatric consultation to my minor son/daughter.

Name of Student: _____

Student KSU ID# _____

I understand that:

My son/daughter has the right to refuse diagnostic or treatment services

Any specific information, which my son/daughter shares in counseling, will be treated with the strictest confidentiality. I also understand that there are important legally mandated exceptions to confidentiality. These include the following:

- Notification of relevant others when a clinician judges that [illegible]