

**CONSENT TO RECEIVE SERVICES
FROM STUDENT HEALTH PROGRAM
MENTAL HEALTH SERVICES**

I, _____, the
(Relative or Guardian's Name)

_____ of _____
(Relationship to Child) (Name of Child)

who is a child receiving services from Peace Country Health, Mental Health Services – Student Health Program, consent to this assessment and/or treatment and agree to cooperate with Peace Country Health, Mental Health Services – Student Health Program in helping this child.

Signed at _____ on _____
Date (day/month/year)

Printed Name Signature

Relationship Witness

This consent expires after one year. I understand that this consent may be revoked by me in writing at any time. A photocopy or facsimile shall be as valid as the original.