



**Washington University in Saint Louis
Mental Health Services**

Parental Consent Form

I, _____, as legal custodial parent/legal guardian of
_____, do hereby give my consent for
(student's name)

Washington University's Mental Health Services to provide treatment to my child. Treatment may consist of assessment, psychological testing, individual and/or group counseling, medications, collaboration with other W.U. organizations, referral to a therapist for open-ended treatment off campus, or referral to a hospital emergency room.

I understand that, as long as my child is not allowed under state law to consent to treatment him/herself, I may discuss my child's status and any recommendations which Washington University may have. I further understand that my signature does not imply authorization to release information and that I have the right to revoke this consent at any time.

Parent/ Guardian Signature: _____

Date: _____

Witness Signature: _____

Date: _____

Please fax to Jenny King at 314-935-8515 or email jaking@wustl.edu