Consent for Treatment

Client: ________________________ **DOB**: ____/____/_____

I, _________________________ hereby authorize ☐ **Wraparound** ☐ **Reach** to:
Parent/Guardian Name (Print)

1. Evaluate and treat the above named child.
2. Secure necessary medical/laboratory services for the above name child.

____ I understand that no treatment involving the use of specific medications will be provided without my knowledge and with my approval in writing.

____ I understand that the services above are provided on a continuing voluntary basis and that I may revoke permission for any or all of the above in writing at any time.

____ I understand that this consent will remain in effect until above named child is dis-enrolled from

☐ **Wraparound** ☐ **Reach**

Parent/Guardian Signature: _________________________ **Date**: _____/_____/______

Client Signature: _________________________________ **Date**: _____/_____/______

Staff Signature: __________________________________ **Date**: _____/_____/______